YourMD, S. William Pierce, M.D.

When registering, please present a form of picture identification. Payment is expected at the time of service, unless other arrangements are made. Thank you very much for choosing us for your medical needs.

Patient Information

Name_____

Address_____

City_____State__Zip_____

Phone #1 ( ) _____

Phone #2 ( ) _____

E-Mail _____**

Marital Status S/M/W/D/O

Date of Birth _____Age_____ Sex_____

Social Security # _____ §§

Responsible Party (If other than patient)

Name _____

Address _____

City _____State ___Zip_____

Relationship _____

Social Security # _____§§

Date of Birth _____

Emergency Contact

Name _____

Relationship _____

Address _____

City _____ State _____ Zip _____

Phone #1 ( ) _____

Phone #2 ( ) _____

Patient

Employment Information

Employer_____

Occupation _____Status ___

Work Address _____

City _____ State _____ Zip_____

Work Phone # _____

§§ We will not release your Social Security # without your permission.

****E-mail addresses will only be used by our office and will not be released to any one else for any purpose. By listing your email address, you are allowing YourMD to send you a quarterly newsletter and correspond with you regarding your medical questions/issues. You are also acknowledging that this is a secure email address that you have sole and exclusive access to the address listed and you can receive confidential medical information at this address.**

☐ **check box if you do <u>not</u> wish to receive quarterly newsletter**

Whom may we thank for your visit?_____

Please remember, Insurance is <u>not</u> considered a method of reimbursing the patient for fees paid to the doctor. It is your responsibility to pay contracted fee. Occasionally, the doctor may render services not covered by your contracted fee. These services are additional to those listed in your contract and fees for these services are expected at the time of service. YourMD has negotiated fees for many outside services and specialist. These fees are exclusive to our member patients and payment is expected for those services at the time they are provided by the outside agency. The fees are paid directly to that entity and we have no control over those entities.

Failure to pay at time of service per your signed contract could result in cancellation of your agreement with YourMD.

Please be aware in certain circumstances, specimens obtained in the office may be sent to the lab for further testing. You will be billed separately for those services, at our negotiated costs. Payment is expected at the time those costs are known.

If this account is assigned to a collection agency for collection and/or suit, the practice shall be entitled to reasonable attorney fees and costs.

1. **I understand that I am financially responsible for charges incurred at office that are not covered in my contract.**

2. Carefully read and acknowledge the following: **<u>INITIAL</u>**

Please be advised that this office will NOT prescribe any narcotics or Benzodiazepines on the first visit.	
There is an office charge of $25.00 for returned checks.	
We may require up to 48 hours to honor refill prescription requests called into this office.	
If you call and need to speak with the doctor, a message will be taken. In most cases, phone calls will be returned by the end of the day.	
We require at least 4 hours notice for appointment cancellations.	

This assignment will remain in effect until revoked by me in writing. A photocopy/facsimile of this assignment is to be considered as valid as the original.

<u>I certify that all information I have provided is true and correct to the best of my knowledge</u>.

Signature_____Date_____/_____/_____