Noel R. Williams, M.D, F.A.C.O.G.
Christina McFarland, PA-C
Abbey Ronck, PA-C
Jan Nelson Kimball, L.C.S.W.
1705 S. Renaissance Blvd #120 ● Edmond, OK 73013 ● (405) 715-4GYN (4496) ● Fax (405) 715-4499

New Patient Information

Please print neatly and fill in all blanks

Patient's Legal Name: _____
(first) (middle) (last)

Birth Date:____/ ____/ _____ Age: _____ Social Security No. _____ - _____ - _____

Circle One: Single Married Divorced Separated Other:_____

Patient's Address: _____
(street address) (city) (state) (zip)

Home Phone: _____ Work Phone: _____ Cell: _____

Employer: _____

Primary Care Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

How did you hear about our practice? _____

Name of the Primary Insurance Company: _____

Name of the person who carries the insurance policy: _____ Relationship to Patient: _____

Carriers DOB: _____/_____/_____ Carriers SSN: _____- _____- _____

Carriers Employer: _____ Carriers Work Phone Number: _____

Secondary Insurance Company (if applicable):_____

Name of the person who carries the insurance policy: _____ Relationship to Patient: _____

Carriers DOB: ___/____/____ Carriers SSN: _____

Carriers Employer: _____ Carriers Work Phone Number: _____

Spouse's Name: _____ Ph #:_____

Nearest relative not living with you: _____Relation: _____ Ph #: _____

If patient is minor, please list **both** parents information:

Mother: _____ Employer: _____ Ph #:_____

Father: _____ Employer: _____ Ph #: _____

I hereby authorize my insurance benefits to be paid directly to the facility and the physician and I am financially responsible for non-covered services. I also authorize the physician to release my information in the processing of any insurance claims. I acknowledge and agree that I have received a copy of the HIPPA Privacy Notices.

Signature Date

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Authorization to Release Information via phone/Family/Friends

Print your name: _____ DOB: _____

I hereby authorize confidential communications from the physicians or staff of this office regarding my health care, lab work, test results, treatments, appointments, prescriptions, etc… to be received at any of the phone numbers listed below. I authorize the staff to leave messages on the voice mail or with the individual who answers the phone at any of the below numbers:

(Do not fill in numbers at which you do NOT wish to be contacted)

Home Phone: _____ Cell phone: _____ Other: _____

I authorize the following individuals (**spouse, family member, and/or friend**) to call the office on my behalf to verify the status of appointments, treatment plan, medications, and/or account information. These individuals may also pick up prescriptions and/or samples that I have requested: **(Leave blank if you do not authorize any other individual to access your protected health information)**

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Below is the pharmacy and pharmacy phone number that I will use for all prescriptions: (for your convenience phone books are located throughout the lobby.)

Pharmacy Name: _____ **Pharmacy Number**: _____

I understand this authorization will remain in effect until I revoke the authorization <u>in writing</u>.

_____ _____

Patient Signature Date

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AUTHORIZATION FOR TREATMENT

I hereby authorize the Physician(s) in charge of the care of the patient to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR INSURANCE CLAIMS

I hereby authorize the physician(s) to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of the physician's charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the physician's treatment or charge including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, welfare funds, the Social Security Administration or it intermediaries or carriers. **I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INIDCATES THAT I HAVE A COMMUNICABLE DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).** With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning identity, and release TPG, it agents and employees from liability in connection with the release of information contained therein.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit. I understand I am financially responsible for charges not covered by this assignment.

I understand a photocopy of this document is as valid as the original.

_____ Date: _____
Patient's Signature

_____ Date: _____
Or Responsible Party Signature (parent of minor, etc…)

Noel R. Williams, M.D.
1705 S. Renaissance Blvd, #120
Edmond, OK 73013
Phone 405-715-4496 Fax 405-715-4499

Dear Patient:

At the office of Noel R. Williams, M.D. we pride ourselves on offering our patients the most advanced preventative care available. We now offer our patients the only FDA-approved high-risk HPV (human papillomavirus) test. This screening is a highly sensitive viral test used in conjunction with a Pap test for Cervical Cancer screening in women. Persistent infection with HPV is the primary cause of cervical cancer.

A few important things to know about HPV and cervical cancer screening:

- Most women will have HPV at some point during their lives but very few will develop cervical cancer.
- Cervical cancer develops if an HPV infection persists for many years.
- The Pap test looks for abnormal cell changes on the cervix that occur as a result of a persistent high-risk HPV infection. The HPV test looks for an HPV infection.
- When used together, these tests can show with nearly 100% certainty that you do not have cervical disease. Women, who test negative for HPV and have a normal Pap test, have virtually no risk of developing cervical cancer before their next scheduled visit.
- Knowing your HPV status helps you and your provider determine how often you should be screened. Early detection of pre-cancerous cell changes is the KEY to PREVENTING cervical cancer.
- Your HPV status IS NOT a reliable indicator of your (or your partner's) sexual behavior. HPV can lie dormant in cervical cells for many years before becoming an active infection.
- **If you're not sure you should have the HPV screening, please speak with your provider before completing form.**

IMPORTANT INSURANCE INFORMATION:
Most insurance companies cover the HPV test when used with a Pap test for cervical cancer. However, the individual benefits of your insurance may or may not cover the screening. Our office will not know if it is a covered service until the claim is submitted. The approximate cost for an HPV test is $100-$200 depending on the lab your insurance requires. **If the test is not paid for by your insurance company you be responsible for the cost of the screening.**

☒ I have read the above information and **AGREE** to have the HPV test with my pap test. I also agree to pay for the HPV test should my insurance not cover the test.

☒ I have the above information and **DO NOT** wish to have the HPV test at this time.

Please print name legibly: _____

Date of Birth: _____/ _____/ _____

X _____ _____
Patient Signature Date