

WOMEN'S CARE SPECIALISTS, P.C.

2006 Brookwood Medical Center Drive
Women's Medical Plaza ♦ Suite 600
Birmingham, Alabama 35209
205-877-2971 ♦ 205-877-2541 fax
wcspc.com

Dr. Janet A. Davis
Dr. Karla G. Kennedy

Dr. Elizabeth A. Barron
Dr. Elizabeth C. Duke

PATIENT INFORMATION - Please Print

GENERAL

1. Last Name _____
2. First Name _____ Middle Initial _____
Prefer to be called _____
3. Social Security No. _____
4. Address _____
5. Address (line 2) _____
6. City, State _____
ZIP _____
7. Previous name _____
8. Home phone _____
9. Daytime phone _____
10. Cell phone _____
11. Email _____
12. Occupation _____
13. Employer _____
14. Employer Address _____
15. Marital Status (S / M / D / W) _____
16. Spouse Name _____
17. Spouse Employer _____
18. Spouse Work Phone _____
19. Emergency Contact _____
Address _____
Phone No. _____
20. Primary Physician _____
21. Referring Physician _____
22. Patient's Date of Birth _____
23. Name of Person who referred you to our office _____

INSURANCE

1. Responsible Party _____
Relationship to Patient _____
2. Primary Insurance Co. _____

Group No. _____
Contract No. _____
Policyholder DOB _____
Patient's Relationship to Insured if other than self: _____
3. Secondary Insurance Co. _____

Group No. _____
Contract No. _____
Patient's Relationship to Insured if other than self: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I authorize payment of any medical benefits to the physician providing the medical services submitted for payment that would have otherwise been payable to me. I understand that any amount deemed by my insurance carrier to be beyond the "usual, reasonable and/or customary" charges for said services will be paid by me.

ATTENTION MANAGED CARE ENROLLEES (PMD, United Healthcare, etc.):

I understand that some procedures done by the physician and approved by me are not covered by my individual contract. I accept the responsibility for the immediate payment of the charges not covered by my insurance company and agree to pay attorney's fee, court costs, and any other reasonable costs of collection should I fail to make payment.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the physicians of Women's Care Specialists, P.C. to release any information acquired in the course of my examination or treatment to my insurance company. My medical information includes any and all records related to my diagnosis, treatment, and care, including but not limited to testing which may include HIV and HBV test results.

PAYMENT TERMS:

You will receive two statements on balances due before we start active collections on your account. Any balance written off to bad debt must be paid before receiving routine care, including prescriptions.

- As consideration for the Physician's services, I agree to pay all charges for services at the completion of such services. If payment is not received upon completion of treatment, the Physician may, at his/her discretion, place the unpaid account with an attorney for collection. If this action is necessary, I agree to pay an attorney's fee, court costs, and any other reasonable cost of collection.
- I understand that a check returned by my bank for any reason is subject to a reasonable service charge.
- I have read and understand the above statements.

SIGNATURE _____

DATE _____

WOMEN'S CARE SPECIALISTS, P.C.
 Routine Screening Test Information and Request Form

Your doctor feels strongly that certain tests are important to women for preventive care. Based on guidelines published by the American College of OB/GYNs (ACOG) regarding routine, periodic screenings the physicians recommend the following tests (performed in our office):

* Please choose one *

| | | | |
|--------------------|---|-----------------|--|
| Urinalysis: | A urine specimen is collected to check for excess sugar or protein. | Our Fee \$22.00 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| CBC: | A blood sample is checked for anemia profile. | Our Fee \$22.00 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hemoccult: | If age 40 or over, a stool sample will be obtained during a rectal exam to screen for colon cancer. (This does not replace the colonoscopy recommended at age 50) | Our Fee \$35.00 | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Additionally, ACOG also recommends cholesterol and triglyceride screening every five (5) years for most patients. If you choose to have this done, patients of Dr. Kennedy MUST fast for 12 hours. Drs. Davis, Barron, & Duke prefer fasting preparation, but will agree to check levels otherwise if requested. We will draw the blood specimen for these tests, but the actual test itself will be performed at a laboratory. If our group is a contracted provider for your insurance carrier, this lab must be billed through the laboratory and if your carrier rejects the charges, the lab will bill you THEIR prices if the lab is rejected.

| | | |
|--------------------------|---------------------------------------|--|
| HIV (Aids Screen) | Labcorp Est. Fee \$150 - \$300 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| CHOLESTEROL | Labcorp Fee \$37.00 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lipid panel | Labcorp Fee \$87.00 | <input type="checkbox"/> Yes <input type="checkbox"/> No |

GENERAL INSURANCE COVERAGE FOR TESTING

Depending upon your individual contract, your insurance company may cover the cost of the above tests. Our group must be a contracted provider for your carrier, and the test must be "covered", or you will be required to pay for the tests you select at the time of visit. A form will be given to you for use in filling for any reimbursement you may be due. Some of the major carriers have these policies:

- UNITED HEALTHCARE:** The above tests (except the cholesterol/triglyceride screening) are usually covered as part of the annual exam.
- VIVA:** The above tests (except the cholesterol/triglyceride screening) are usually covered as part of the annual exam.
- BLUE CROSS/PMD:** **YOU MUST CHECK YOUR INDIVIDUAL CONTRACT FOR COVERAGE ON ANY TESTS LISTED.**

I, _____, elect to have the above referenced tests performed, realizing that the test(s) may be a NON-COVERED service, and therefore, I will be responsible for immediate payment in full.

Signature _____ Date _____

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PATIENT HISTORY UPDATE - Please Print

Please take a few minutes to complete this brief questionnaire regarding your health, and plan to mail it prior to your visit.

Name: _____ Date of Birth: _____

- 1) Have you been hospitalized or had any surgical procedures since your last check-up? Yes No

If yes, when and for what reason? _____

- 2) Are you allergic to any medications? Yes No

If yes, please list them. _____

- 3) Please list your current medications: _____

- 4) Check any new health problems you have developed since your last visit.

- | | |
|--|---|
| <input type="checkbox"/> Heart disease or stroke | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Lung or respiratory problems | <input type="checkbox"/> Blood / clotting disorders (anemia, phlebitis) |
| <input type="checkbox"/> Stomach, bowel, or liver problems | <input type="checkbox"/> Severe headaches |
| <input type="checkbox"/> Bladder or kidney infections | <input type="checkbox"/> Seizure disorders |

Other (specify) _____

- 5) Has anyone in your family developed any new health problems such as diabetes, high blood pressure, heart disease, cancer, etc.? Yes No

If yes, which family member and what problem(s)? _____

- 6) Do you smoke? Yes No If so, how much per day? _____

- 7) Do you drink alcohol? Yes No If so, how much? _____

Signature: _____ Date: _____