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 ______

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.

23. Name of Person who referred you to our office ______

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):

<u>* Please choose one *</u>

Urinalysis:	A urine specimen is collected to check for excess sugar or protein.	Our Fee $22.00	❑ Yes ❑ No
CBC:	A blood sample is checked for anemia profile.	Our Fee $22.00	❑ Yes ❑ 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	❑ Yes ❑ 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**	❑ Yes ❑ No
CHOLESTEROL	**Labcorp Fee $37.00**	❑ Yes ❑ No
Lipid panel	**Labcorp Fee $87.00**	❑ Yes ❑ 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 carriors 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.

- ☐ Heart disease or stroke
- ☐ Lung or respiratory problems
- ☐ Stomach, bowel, or liver problems
- ☐ Bladder or kidney infections
- ☐ High blood pressure
- ☐ Blood / clotting disorders (anemia, phlebitis)
- ☐ Severe headaches
- ☐ 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: ____________

REQUIRED CLINICAL INFORMATION FOR MAMMOGRAPHY

NAME:____________________ MR#__________ DATE:__________

AGE:______ DATE OF BIRTH_____/_____/_____ PHYSICIAN:______________

TYPE EXAM (please circle one) SCREENING / DIAGNOSTIC

BREAST HISTORY:

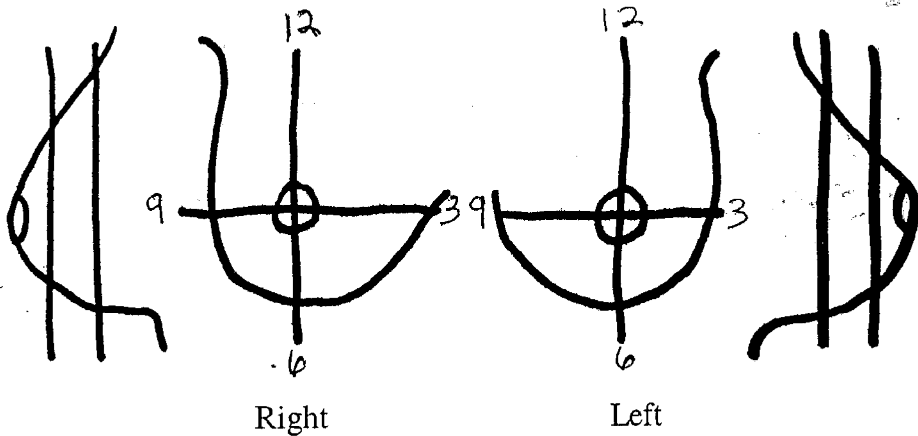
Previous Mammogram: Y / N Year:_______ Facility/City/State:______________

Personal History of Breast Cancer: Y / N Type:______________

Family Members with Breast Cancer:______________

BREAST SYMPTOMS:			How Long	**BREAST SURGERY:**			Date
Lumps/Thickness	R	L	______	Breast Reduction	R	L	______
Nipple Discharge	R	L	______	Breast Implants	R	L	______
Nipple Retraction	R	L	______	Cyst Aspiration	R	L	______
Pain/Tenderness -	R	L	______	Biopsy	R	L	______
Moles/Scars/Bruises	R	L	______	Mastectomy	R	L	______
				Radiation/ Chemo	R	L	______
Are you Pregnant? Y / N				Lumpectomy	R	L	______

PATIENT SIGNATURE: ______________________ DATE: __________



0 Mole

X Lump

//// Scar

Technologists Notes:______________________________________