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	❑ 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______________