2006 Brookwood Medical Center Drive • Women's Medical Plaza
Suite 600 • Birmingham, Alabama 35209
Phone (205) 877-2971 • Fax (205) 877-2964
Janet A. Davis, MD Karla Kennedy, MD Beth A. Barron, MD Margot Gathings, MD

Patient Information _____ **Preferred Physician**_____

Last Name: _____ First _____ Middle _____

Preferred: _____ DOB: _____ Sex:_____

Social Security Number: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Other ☐ Decline to report

Ethnicity: ☐ Hispanic/Latino ☐ not Hispanic/not Latino ☐ Decline to report

Preferred Language: ☐ English ☐ Spanish ☐ Other_____

Marital status: S / M / D / W **Spouse's Name**_____

Address: _____

Zip: _____ City: _____ State: _____ County: _____

Phone: Home: _____ Work: _____ Cell: _____

Fax: _____ Email: _____

Preferred Communication: ☐ Home ☐ Work ☐ Cell ☐ Email ☐ Text

Primary Physician_____ **Referring Physician**_____

Preferred Pharmacy: **I consent to allow Women's Care Specialist to retrieve my prescription history from my pharmacy:** ☐ Yes ☐ No

Name: _____

Address: _____

Phone: _____

Employer: _____ Occupation: _____ Work Phone:_____

Phone or Ext: _____

Emergency Contact:

Name:_____ Relationship:_____ Phone:_____

Insurance Information:

Primary_____ ID#_____ Group#_____

Subscriber_____ Relationship_____ DOB_____

Secondary_____ ID#_____ Group#_____

Subscriber_____ Relationship_____ DOB_____

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 bee 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 (PMS, UNITED HEALTHCARE, ETC.): I understand that some procedures done by my individual 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/he 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:**

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ACKNOWLEDGEMENTS - Please initial each disclaimer and sign.

Preventive Services Disclaimer – I have reviewed the Preventive Services Disclaimer displayed in the waiting area and I understand that my insurance may apply a co-payment for any additional services rendered outside the scope of the Preventive Services provided by the Affordable Care Act. Initials _____

Formulary Benefits Data – We ask your permission to obtain formulary information, and information about other medications prescribed by other providers using SureScripts. A detail explanation regarding this request in displayed in our waiting area. Initials _____

Notice Of Privacy Practices - I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights of Women's Care Specialist, P. C.
Initials _____

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You have the right to revoke this consent. By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

There is no expiration date for this Consent.

You may communicate with the following individuals regarding my condition or course of treatment, invoices for services, appointment reminders and test results:

_____

You may communicate confidential information to me regarding my conditions or course of treatments, invoices for services, appointment reminders and test results to the following address, e-mail or phone number:

_____

_____ _____
Individual Signature Date

As a personal representative, I have authority to act for the individual because I am the individual's _____

PATIENT HISTORY UPDATE - Please Print

Please take a few minutes to complete this brief questionnaire regarding your health.

Name: _____ Date of Birth: _____

1) If you are still Menstruating, when was the first day of your most recent period? _____

2) Menopausal? ❑ Yes ❑ No

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

If yes, when and for what reason? _____

_____

4) Are you allergic to any medications? ❑ Yes ❑ No

If yes, please list them. _____

5) Please list your current medications: _____

_____

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

❑ Heart disease or stroke ❑ High blood pressure

❑ Lung or respiratory problems ❑ Blood/clotting disorders (anemia, phlebitis, blood clot)

❑ Stomach, bowel or liver problems ❑ Severe headaches ❑ Diabetes

❑ Bladder or kidney infections ❑ Seizure disorders ❑ Cancer Type: _____

❑ Other (specify) _____

7) 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)? _____

_____

8) Do you currently smoke? ❑ Yes ❑ No If so, how much per day? _____

Have you smoked previously? ❑ Yes ❑ No

9) Do you drink alcohol? ❑ Yes ❑ No If so, how much? _____

Have you previously consumed alcohol? ❑ Yes ❑ No

Signature: _____ Date: _____

WOMEN'S CARE SPECIALISTS, PC

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ROUTINE SCREENING TEST INFORMATION AND REQUEST FORM

Your doctor feels strongly that certain tests are important to women for preventive care.

ased 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):

Urinalysis:	A urine specimen is collected to check for excess sugar or protein.	Our Fee $10.00	❑ Yes ❑ No
CBC:	A blood sample is checked for anemia profile.	Our Fee $16.00	❑ Yes ❑ No

tionally, 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, on, & 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 preformed at a laboratory. If our p 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) - 86703	Labcorp Est. Fee $159 - $471	❑ Yes ❑ No
CHOLESTEROL - 82465	Labcorp Fee $37.00	❑ Yes ❑ No
Lipid panel - 80061	Labcorp Fee $93.00	❑ Yes ❑ No

GENERAL INSURANCE COVERAGE FOR TESTING

ending 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 vered", or you will be required to pay for the tests you select. If you elect to have test that are performed within our office we will collect payment for these test at the time of service if we ect the test will not be covered by your insurance. If you elect to have a test that is not completed in our office you will be billed by the testing facility if it is not covered by your insurance.

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.

I, _____, decline to have the above reference tests performed.

Date_____

Patient Name: _____ **Account #**_____

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Dr. Elizabeth Barron
Dr. Margot Gathings
Dr. Karla Kennedy
Dr. Janet Davis

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION TO PRIMARY CARE PHYSICIAN:

PLEASE FILL FORM OUT COMPLETELY

Primary Care Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Description of information to be disclosed- I authorize Women's Care Specialists, P.C. to disclose the following protected health information about me to the entity, or identified above:

□ I decline any information to be released to my Primary Care Physician

□ Recent Pap Results

□ Recent Mammogram Report

□ Recent Ultrasounds

□ Recent Office Note

□ Labs

□ Bone Density Test

□ Other (Please Specify): _____

Patient Signature: _____ Date: _____

Expires one year from Date of Signature