DOCTOR: Susan Vance, M.D. Brittney Laughlin, D.O. Theodore Catranis, M.D. Jessica Jones, M.D.

Who may we thank for referring you to our office?_____

Patient Name:_____ Patient Birthdate: _____/_____/_____
(last) (first) (middle initial)

Patient Age:_____ Patient Social Security #:_____/_____/_____ Marital Status:_____

Patient Race:_____

Mailing Address or PO Box:_____

City:_____State:_____Zip:_____ E-mail:_____

Home Phone:(____)_____-_____ Cell:(____)_____-_____ Work Phone:(_____)_____-_____

Employment Status: □ Full-Time □ Part-Time □ Unemployed □ Student □ Retired

Employer:_____

Emergency Contacts

Name:_____ Relationship:_____

Home Phone:(____)_____-_____ Cell Phone:(____)_____-_____ Work Phone:(_____)_____-_____

Person responsible for any balance on this account-(only if the patient is a minor)

Name:_____ Social Security#:_____/____/_____

Relationship:_____ Birthdate: _____/_____/_____

Street Address:_____ City:_____ State:____ Zip:_____

Home Phone:(____)_____-_____ Cell Phone:(____)_____-_____ Work Phone:(_____)_____-_____

Employer:_____

Employment Status: □ Full-Time □ Part-Time □ Retired □ Unemployed

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Primary Insurance Information ****Please present all insurance cards to the Receptionist****

Insurance Company:_____

Name of Policy Holder/Insured:_____ Insured Date of Birth:____/___/_____

Relationship to Patient:_____ Employment Status: □ Full-Time □ Part-Time □ Retired □ Unemployed

Second Insurance (if applicable)

Insurance Company:_____

Name of Policy Holder/Insured:_____ Insured Date of Birth:____/___/_____

Relationship to Patient:_____ Employment Status: □ Full-Time □ Part-Time □ Retired □ Unemployed

Third Insurance (if applicable)

Insurance Company:_____

Name of Policy Holder/Insured:_____ Insured Date of Birth:____/___/_____

Relationship to Patient:_____ Employment Status: □ Full-Time □ Part-Time □ Retired □ Unemployed

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FINANCIAL RESPONSIBILITY – I understand that I am responsible for all charges not paid by my insurance plan except those amounts that WHAM is contractually obligated to write off. I understand that I am responsible for all non-covered services and by signing this form I acknowledge I have been made aware of my obligation prior to receiving such services. I understand that if I do not pay for the charges for which I am responsible for, WHAM may turn my account over to a collection agency. I understand that should my account be turned over to a collection agency, I may be charged a collection fee, not to exceed 25% of my account, and I accept these fees charged by WHAM as a legal and lawful debt and agree to pay such fee if charged. Please remember that your insurance policy is a contract between you and your insurance carrier. Patients without insurance are expected to pay at the time the service is rendered.

Well (Preventive) vs. Sick Visit-A well visit is an appointment in which the patient has no complaints/concerns or medical diagnosis. This is considered a routine preventive visit. A sick visit is when the patient has complaints/concerns, a pre-existing diagnosis, or the physician discovers a medical concern that needs to be addressed that day. If your appointment is for a well exam and there is also a concern addressed that day, you may be charged an office visit in addition to your wellness visit. In this case, your regular co-pay and/or deductible will apply in addition to your wellness co-pay and/or deductible (if applicable).

Late Arrivals - Patients arriving more than 15 minutes late for a scheduled well visit will be rescheduled for another day. Patients arriving more than 15 minutes late for an acute visit will be worked in and seen as soon as the schedule allows.

Prepaid Planning – Patients who are preparing for a birth or planning for a surgery will be required to pay the estimated patient responsibility prior to the service being rendered. The patient's estimated portion of obstetrical care is required by the end of the 7th month of pregnancy. The estimated balance due for procedures is due prior to the service being scheduled. Our Patient Accounts Representative will verify your benefits and inform you of the balance due.

Co-pays are due at the time of your service**.**

No Show Appointments and Late Cancelations – I understand when I make an appointment time is reserved for me that cannot be scheduled for someone else. Recognizing this I will, exempting unforeseen emergencies, notify WHAM no later than the business day before my appointment should I not be able to keep my appointment. If I do not, I understand WHAM has the right to charge me a no show fee and I acknowledge such a charge would be a legal and lawful debt and agree to pay such fee if charged.

Returned Check (NSF) - If you present a check that is returned to Women's Health Alliance for non-sufficient funds, a $30.00 fee will be charged to your account.

Forms - Completing disability forms and/or FMLA forms is not a medical service and is not paid by insurance. There is a $10 fee for completing each set of forms. Please provide at least one week notice or lead time for completion.

Medical Records - There is a fee for copying medical records which complies with Alabama state law. A legal release is required and payment in advance is required.

Laboratory Services - Please remember that specimens sent to labs outside the WHAM laboratory are billed separately from lab performed in our office. You will be billed separately from the laboratory.

Minors – I understand that I am responsible for this child's account and any agreement otherwise by means of a court decree or other valid agreement is between me and another party.

Assignment of Benefits –I request that payment of authorized Medicare and/or Medicaid benefits to me or on my behalf for services in or by WHAM shall be made to WHAM, and I specifically assign such benefits to the WHAM. If applicable, I hereby assign and authorize payment directly to WHAM all medical benefits under any insurance or third party plan payable to me or which I am otherwise entitled.

Authorization to Treat – I voluntarily consent to medical treatment and diagnostic procedures provided by Women's Health Alliance of Mobile. I/we are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the results of treatments and/or examinations.

Patient or Responsible Party Signature:_____ Date:_____