

7540 Cipriano Ct., Suite C  
Fairhope, Alabama 36532  
Phone (251) 990-1985 \* Fax (251) 990-1986

\*\*This information is updated yearly for office purposes\*\*

Patients

Legal Name: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First MI Maiden Name Preferred Name

DOB \_\_\_\_\_ Age \_\_\_\_\_ SSN \_\_\_\_\_ DL # \_\_\_\_\_ State \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Phone No (\_\_\_\_\_) \_\_\_\_\_ Cell No (\_\_\_\_\_) \_\_\_\_\_ Marital Status: \_\_\_M\_\_\_S\_\_\_W\_\_\_D\_\_\_Other

Patient's Employer: \_\_\_\_\_ Phone No: (\_\_\_\_\_) \_\_\_\_\_

Employers Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Spouses Employer Phone No :(\_\_\_\_\_) \_\_\_\_\_ Spouse's Cell No :(\_\_\_\_\_) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone No (\_\_\_\_\_) \_\_\_\_\_  
(\*If other than spouse)

**PLEASE PRESENT YOUR INSURANCE CARD (S) AND DRIVER'S LICENSE FOR PHOTOCOPY**

**INSURANCE INFORMATION:**

1<sup>st</sup> Insurance Company: \_\_\_\_\_ Member/  
Contract No: \_\_\_\_\_ Group No: \_\_\_\_\_

2<sup>nd</sup> Insurance Company: \_\_\_\_\_ Member/  
Contract No: \_\_\_\_\_ Group No: \_\_\_\_\_

**\*\*\*\*RESPONSIBLE PARTY INFORMATION: (\*\*\*\*This is the person who has the insurance, if other than the patient.)**

1. Name: \_\_\_\_\_ Phone No. (\_\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

2. Name \_\_\_\_\_ Phone No. (\_\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Referred by: \_\_\_\_\_

**Guarantee of Payment**

I, the undersigned, hereby agree to pay all amounts and charges incurred by members of my family for services rendered by our physician(s). I further agree that it is my responsibility to know and understand the provisions and limitations stated in my insurance policy as well as the current list of providers in my contract, and accept full responsibility for all charges not covered by my insurance. Failure to make payment requested is basis for legal action and the undersigned agrees to pay all costs of collection, including a reasonable fee and waives his/her right of exemption under law of the State of Alabama and any other state.

**Assignment of Benefits**

In consideration of care and services rendered to me by physician(s) during this office visit, I assign the benefits payable under my insurance policies for physicians services to the physician furnishing the services or to their authorized billing agent insofar as necessary to cover their charges. I authorize such physician(s) or their billing agent to submit a claim to my insurance carrier for payment for me and authorize payment to be made directly to said physician(s) billing agent or organization.

**Assignment of Claims Against Third Parties**

In consideration of care rendered to me by physician(s), I hereby assign to the physician(s) rendering services all claims that I may have against third parties who may be liable for any of my medical expenses, to the extent necessary to cover my expenses for physician(s) care and services. Any funds received by me in connection with such claims against third parties, or settlement of such claims, shall be paid to the said physician(s) to cover my expenses. I hereby authorize payment directly to said physician(s) or their authorized billing agent of any of the above-mentioned funds which are otherwise payable to me but not to exceed the regular reasonable charges for this service.

**Medicare Benefits to Physician(s)**

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf for any services furnished to be by physician(s). I authorize any holder of medical or other information about me to be released in order to process claim(s) and request payment of my benefits to the physician rendering service.

**Authorization to Release Information**

I hereby authorize physicians rendering services to release to my insurers, billing and certain medical information including final diagnosis and operative procedure(s) relative to this or related hospital claim(s) and/or office claim(s) for the purpose of determining eligibility for coverage and payment of charges for services rendered in connection with this hospitalization and/or office care. I also give permission for my physician to release my medical information to another physician assisting in my healthcare.

**Privacy Notice**

I hereby acknowledge receipt of your practice's privacy notice and understand that your Privacy Policy is posted in your patient waiting room.

**(Please complete all information IF person financially responsible is someone other than patient)**

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_  
\*\*\*Signature of Patient Required

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Financial Guarantor

\_\_\_\_\_  
Date

Patients Name \_\_\_\_\_

Date \_\_\_\_\_

I authorize **Brown & McCool Gynecology** to contact me in reference to any items that will assist the practice in providing optimal care such as appointment reminders, insurance items, billing inquiries, and any information pertaining to my clinical care, including laboratory results. I authorize the following methods of communication for the items listed above:

mail                      e-mail                      home telephone                      cell phone                      voicemail/answering machine

Email Address (Please Print) \_\_\_\_\_ Phone Number \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Pharmacy Phone Number \_\_\_\_\_

**With my consent, all financial and/or medical information can be given to the following people:**

Name	Relationship	Phone Number
Financial      Medical		

Name	Relationship	Phone Number
Financial      Medical		

Name	Relationship	Phone Number
Financial      Medical		

By signing below, I understand that I am allowing **Brown & McCool's** staff to speak to the above identified person(s) in reference to any and all of my Personal Health Information (PHI). I also understand that I can change this list at anytime by appearing in person or in writing by sending a request to the office of **Brown & McCool Gynecology** 7540 Cipriano Ct., Suite C, Fairhope, Alabama 36532.

\_\_\_\_\_  
Patient Signature required (if 14 and older)

\_\_\_\_\_  
Legal Guardian Signature

Name: \_\_\_\_\_ DOB \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Your Family/Internal Medicine Physician: \_\_\_\_\_ Date of your last visit: \_\_\_\_\_

Please complete the following forms. This information will assist us in your evaluation today.

REASON FOR TODAY'S VISIT:

- I need a gynecological exam.
- I am having a specific problem: Please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. List any allergies and reactions to the allergy: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. List current medications, including prescribed medications, vitamins, herbals or diet supplements and other over-the-counter medications; List dosages and the dates started. Attach medication list if you have one.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Current method of contraception: (oral, IUD, tubal, vasectomy, other) \_\_\_\_\_

5. DATES OF YOUR LAST:  
Mammogram \_\_\_\_\_ Pap Smear \_\_\_\_\_ Bone Density \_\_\_\_\_  
Colonoscopy \_\_\_\_\_

6. PAST MEDICAL PROBLEMS AND DATES OF PROBLEMS: (ex: hypertension, diabetes)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. PAST SURGERIES AND DATES OF EACH SURGERY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## REVIEW OF SYSTEMS

Do you currently have any problems related to the following systems?

Please circle: Yes or No

**Constitutional:**

Fever                    Yes    No  
 Chills                    Yes    No  
 Weight-loss            Yes    No

**Eyes:**

Glaucoma                Yes    No  
 Cataracts                Yes    No

**Cardiovascular:**

Chest pain                Yes    No  
 Irregular heart beat    Yes    No  
 Feet Swelling            Yes    No

**Respiratory:**

Shortness of breath    Yes    No  
 Wheezing                Yes    No  
 Frequent cough        Yes    No

**Gastrointestinal:**

Nausea                    Yes    No  
 Vomiting                 Yes    No  
 Abdominal pain        Yes    No  
 Heartburn                Yes    No  
 Recent changes in  
 Bowel habits            Yes    No

**Hematologic/Lymphatic:**

Blood Clotting Problems    Yes    No  
 Swollen glands                Yes    No

**Breasts:**

Masses                        Yes    No  
 Nipple discharge            Yes    No

**Musculoskeletal:**

Muscle Pain                Yes    No  
 Joint pain                    Yes    No

**Psychological:**

Anxiety                        Yes    No  
 Depression                    Yes    No

**Allergies:**

Drug Allergies                Yes    No  
 Hay Fever                      Yes    No

**Genitourinary:**

Urinary frequency            Yes    No  
 Urinary loss                 Yes    No  
 Nighttime urination        Yes    No  
 Painful urination            Yes    No  
 Vaginal discharge/odor    Yes    No



## Financial Policy 2010

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Thank you for choosing Brown & McCool Gynecology. Our entire team is committed to providing you with the best possible quality medical care and services. Please understand payment for our service is part of your treatment and care. Our primary concern is to provide you with the highest quality of medical care and treatment. Knowledge of your individual insurance plan coverage remains your responsibility, therefore we urge you, as a patient to check with your insurance company prior to any testing or surgery to be performed.

There may be certain services that are necessary for the maintenance of your good health, (example: laboratory, urinalysis, ultrasound, hemocult, etc.) that are not covered by your insurance company. Any charges not covered by your insurance company will be your responsibility.

*Let us reassure you that we will order only those tests we feel are necessary for your treatment and optimal care. If you have any questions, someone in our office will be happy to assist you. Thank you very much for understanding and trusting us with your medical care.*

**You are responsible for all required payments of co-payments, deductibles, and co-insurance on the day of your visit.**

We accept cash, VISA, MasterCard, or your personal check as payment. Please note we have a \$40.00 returned check fee. **If we must bill you for two consecutive past due balances for co-payments and deductibles, our system will automatically send the account to collections.**

### **No Insurance Coverage**

Payment is required at the time of service. Please call your insurance company prior to your appointment for information:

### **Do I need a referral?**

If your health insurance plan requires an authorization, please call your primary care physician. Authorization is needed prior to your appointment time.

### **Minor patients**

The parent/guardian/adult accompanying a minor child is responsible for payment. Any child over 18 is legally an adult and is responsible for all services rendered.

### **Cancellation Policy/No Shows**

Time has been specifically reserved for your physician appointment, procedure or treatment. Please call at least 24 hours ahead of time if you must cancel an appointment. There is a \$25 charge if you fail to show up for a scheduled appointment or cancel with less than 24 hours notice. Laser Hair Removal Treatments will be charged the full price of laser treatment scheduled.

Signature \_\_\_\_\_ Date \_\_\_\_\_