WALTER J. LAWRENCE, M.D., P.C., L.L.C.

551 Glover Avenue, Enterprise, AL 36330

Name: _____

DOB: _____ SSN: _____

Marital Status: _____

Address: _____

City, State, ZIP _____

Home Phone: _____ Mobile Phone: _____

E-mail address: _____

Place of Employment: _____

Work Phone: _____

	Primary Insurance	Secondary Insurance
Insurance Name:	_____	_____
Policy Holder Name:	_____	_____
Policy Holder DOB:	_____	_____
Policy Holder SSN:	_____	_____
Relationship:	_____	_____
Policy/Benefits #:	_____	_____
Group #:	_____	_____

Other Insurance: _____

Please list the people with whom we may discuss your medical care:

Emergency Contact Name: _____

Emergency Contact Phone: _____

Other: _____ _____

_____ _____

_____ _____

SIGNATURE: _____ Date: _____

Patient Financial Policy

Thank you for selecting Dr. Lawrence and Walter J. Lawrence, M. D., P. C. as your healthcare provider. We are committed to providing you with compassionate and quality healthcare. The following is a statement of our financial policy. Please read, sign, and date this policy prior to treatment. For your convenience, our practice accepts Visa, MasterCard, Discover, American Express, Cash, and most Personal Checks. You must provide your current insurance card and picture identification to the receptionist for photocopying at each appointment. In the event that no insurance is available, or it has been determined that the patient is ineligible for coverage of services, the patient account will be determined to be self-pay and payment in full is due at the time of each service. Please notify the office staff of any concerns regarding financial limitations pertaining to your treatment plan, as there may be alternative options available.

Insurance --- We accept the assignment of benefits for most insurance plans. However, we cannot guarantee that we are able to participate with each and every insurance plan in the marketplace. Your insurance policy is a contract between you and your insurance carrier; therefore, we recommend that you contact your insurance to confirm our status with your plan. Seeing non-network providers can affect your out-of-pocket expenses. It is your responsibility to confirm we are participating with your particular plan. In addition, we recommend that you determine if you have been assigned a designated primary care provider other than Dr. Lawrence. We require that all co-payments, co-insurance, and deductibles be paid at the time of service. You are responsible for providing our practice with the correct insurance information at the time of service. Should your insurance company fail to pay the insurance claim for services rendered by Walter J. Lawrence, M. D., P. C., you may be responsible for the entire charges submitted to the insurance carrier. For that reason, we recommend that you follow-up with the insurance carrier if your claim has not been paid within 30 days from the date the claim was submitted.

If your insurance coverage is verified and certain procedures are not covered by your insurance, you will be required to sign a waiver indicating that you understand that your policy does not cover this service and that you will be responsible for the charges associated with this service.

Co-insurance, deductibles, and any balances that remain the responsibility of the patient, according to the insurance carrier terms, should be remitted to the practice upon notice of balance due. Any payment for services rendered by Walter J. Lawrence, M. D., P. C. that is paid directly to you should be turned over to the practice immediately.

Failure to remit payment or balances due may result in the patient's account being turned over to an outside collection agency. Up to 33% collection fees can be assessed by the collection agency and will become the financial responsibility of the patient.

Non-insured --- Patients that are not covered by an insurance plan are determined to be self-pay, and are responsible for services rendered at the time of service. Payment in full is expected at the time of service, unless prior arrangements have been approved.

Failure to remit payment or balances due may result in the patient's account being turned over to an outside collection agency. Up to 33% collection fees can be assessed by the collection agency and will become the financial responsibility of the patient.

Missed appointments --- Please help us serve you better by keeping scheduled appointments. In the event you are unable to keep your appointment, please give at least 24 hours' notice. Failing to provide 24 hours' notice of cancellation (i.e. same-day cancellation or no-show) may result in a $35.00 missed appointment charge for regular appointments and $50.00 for DOT/FAA flight physical appointments. This charge is the responsibility of the patient and is not covered by most insurance carriers. Two unexcused missed appointments justify dismissal from the practice.

Refills, Prior Authorizations, Referrals, Letters, & Forms --- An administrative charge may be filed against your insurance for medication refills, prior authorizations (P.A.'s), and referrals for the time incurred to process requests. Please contact our office if you have any questions. Disability, Life Insurance, formal letters, and other forms are often requested to be completed by the practice. Many of the forms require review by the physician and completion of detailed medical history questionnaires. Please contact our office, with a copy of the paperwork to be completed, if there are any questions. Please allow 3-5 days for completion of any requested forms. The charge for this service is directly dependent on the amount of time preparation required. The fee for paperwork ranges from $25.00 to $250.00 per hour. This charge is payable upon submission of the forms, therefore forms will not be completed unless pre-payment is collected.

Record Requests --- Patients may request a copy of their medical record for an administration fee of $25.00 per record requested. Only records generated by this clinic will be provided. If you are transferring care to another provider, upon receiving a patient-signed release, our office will send a copy of your record directly to the provider free of charge.

Returned Checks --- All returned checks shall be assessed a $40.00 bank processing fee, for which you will be responsible, in addition to the owed balance on the account. Subsequent payments and balances due must be paid in cash only.

I hereby authorize Walter J. Lawrence, M. D., P. C., to release medical information to my physicians and/or insurance company(ies). I further authorize direct payment from my insurance company(ies) to Walter J. Lawrence, M. D., P. C.
I have read and agree to abide by the financial policy of Walter J. Lawrence, M. D., P. C.

X_____ _____

Signature of Patient or Responsible Party Date

HEALTH HISTORY

ALLERGIES:

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MEDICAL HISTORY:

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Medication Name	Dosage	Frequency	dx

WALTER J. LAWRENCE, M.D.

PAST MEDICAL HISTORY

(Check all that apply. Please specify and include dates, if applicable.)

CARDIOVASCULAR

- o Heart Attack_____
- o Heart Disease_____
- o Heart Murmur_____
- o High Cholesterol_____
- o High Blood Pressure_____
- o Irregular Heartbeat_____
- o Stroke_____
- o Other_____

RESPIRATORY

- o Asthma_____
- o Bronchitis_____
- o Emphysema (COPD)_____
- o Pneumonia_____
- o Other_____

CONSTITUTIONAL

- o Alcoholism_____
- o Cancer_____
- o Chemical Dependency_____
- o Other_____

ENDOCRINE

- o Thyroid Problems_____
- o Diabetes_____
- o Other_____

GASTROINTESTINAL

- o Bowel Problems_____
- o Cirrhosis_____
- o Colitis_____
- o Gallbladder Disease_____
- o Hepatitis_____
- o Hernia_____
- o Hemorrhoids_____
- o Liver Disease_____
- o Rectal Problems_____
- o Stomach Problems_____
- o Ulcers_____
- o Other_____

GYNECOLOGICAL

- o Cancer_____
- o Pregnancy(#/type)_____
- o Cysts_____
- o Endometriosis_____
- o Other_____

GENITOURINARY

- o Bladder Problems_____
- o Kidney Disease_____
- o Kidney Stones_____
- o Prostate Problems_____
- o Other_____

HEMATOLOGIC

- o Anemia_____
- o Bleeding Disease_____
- o Leukemia_____
- o Other_____

MUSKULOSKELETAL

- o Arthritis_____
- o Gout_____
- o Other_____

NEUROLOGIC

- o Epilepsy_____
- o Migraine Headaches_____
- o Other_____

PSYCHIATRIC

- o Depression_____
- o Nervous Disorder_____
- o ADD/ADHD_____
- o Other_____

WALTER J. LAWRENCE, M.D.

PAST SURGICAL HISTORY

(check all that apply, include dates)

BREAST

- o Abscess _____
- o Biopsy _____
- o Cancer Lumpectomy _____
- o Mastectomy _____
- o Other_____

CARDIOVASCULAR

- o Heart Surgery _____
- o Heart Valve Replacement _____
- o Pacemaker Insertion _____
- o Stents _____
- o Other_____

GASTROINTESTIAL

- o Appendectomy _____
- o Cholecystectomy (gallbladder) _____
- o Colon Cancer _____
- o Hernia _____
- o Colonoscopy _____
- o Other_____

GENTIOURINARY

- o Cesarean Section _____
- o Hysterectomy _____
- o Prostate Surgery _____
- o Other_____

SKIN

- o Abscess Drainage _____
- o Skin Lesion or Cancer Removal _____
- o Other_____

MUSKULOSKELETAL

- o Hip Surgery _____
- o Knee Surgery _____
- o Spine Surgery _____
- o Other_____

NEUROLOGIC

- o Head Surgery _____
- o Other_____

RESPIRATORY

- o Lung Surgery _____
- o Other_____

SUBSTANCE USE

- o Cigarettes/Cigar_____
- o Alcohol_____
- o Other_____

Walter J. Lawrence M.D., P.C., L.L.C.
551 Glover Avenue
Enterprise, AL 36330
Phone: 334-475-2058
Fax: 334-489-4308

MEDICAL RECORD RELEASE AUTHORIZATION

NAME: _____

DOB: _____

SSN: _____

I, _____ authorize the disclosure of my protected health information as described herein. I understand this authorization is voluntary and I may cancel this consent at any time in writing to the office of Walter J. Lawrence M.D. I understand that any release, which was made prior to my cancellation, in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized re-disclosure and, once information is disclosed, it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the office of Walter J. Lawrence M.D.

This form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act.

I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether or not I sign this authorization. I understand that I have a right to inspect and to obtain a copy of any information disclosed.

I hereby release the office of Walter J. Lawrence, M.D. and its employees from any and all liability that may arise from the release of information as I have directed.

Walter J. Lawrence, M.D._____

Purpose of Release: Medical Care_____ Legal_____ Insurance_____ Other_____

Specific items or dates needed:

_____

Patient Signature_____ Date_____

Witness_____

Doctor/Office to Request Records From_____