Patient Demographics

Lawrence Medicine
551 Glover Ave. Enterprise, AL 36330
Phone (334) 475-2058 Fax (334) 489-4308

Name: _____ Nickname: _____

Date of Birth: _____ Social Security #: _____

Marital Status: Single Divorced Married Widowed

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Place of Employment: _____

Work Phone: _____

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

Other Insurance: _____

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

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Other Contacts:	Name	Phone	Relationship

Signature: _____ Date: _____

Health History

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Patient Name:_____ Birth Date:_____

1. Is your general health good?_____
2. Has there been a change in your health within the last year?_____
3. Have you been hospitalized or had a serious illness in the last three years?_____
4. Are you being treated by a physician now? For what?_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Circle any that apply)

☐ AIDS/HIV Positive	☐ Congenital Heart Disorder	☐ Heart Failure	☐ Osteoporosis
☐ Alzheimer's Disease	☐ Convulsions	☐ Heart Murmur	☐ Parathyroid Disease
☐ Anaphylaxis	☐ Diabetes	☐ Heart Pacemaker	☐ Psychiatric Problems
☐ Anemia	☐ Drug Addiction	☐ Heart Trouble/Disease	☐ Radiation Treatments
☐ Angina	☐ Easily Winded	☐ Hemophilia	☐ Recent Weight Loss
☐ Arthritis	☐ Emphysema	☐ Hepatitis A or B or C	☐ Renal Dialysis
☐ Artificial Heart Valve	☐ Epilepsy or Seizures	☐ Herpes	☐ Rheumatic Fever
☐ Artificial Joint	☐ Excessive Bleeding	☐ High Blood Pressure	☐ Scarlet Fever
☐ Asthma	☐ Excessive Thirst	☐ High Cholesterol	☐ Sickle Cell Disease
☐ Atrial Fibrillation	☐ Fainting Spells/Dizziness	☐ Hives or Rash	☐ Sinus Trouble
☐ Blood Disease	☐ Frequent Cough	☐ Irregular Heartbeat	☐ Sleep Apnea
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Kidney Problems	☐ Shortness of Breath
☐ Breathing Problem	☐ Frequent Headaches	☐ Leukemia	☐ Stomach/Intestinal Disease
☐ Bruise Easily	☐ Frequent Urination	☐ Liver Disease	☐ Stroke
☐ Cancer	☐ Glaucoma	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Chemotherapy	☐ Gout	☐ Low Blood Sugar	☐ Tumors or Growths
☐ Chest Pains	☐ Hay Fever	☐ Lung Disease	☐ Ulcers
☐ Cold Sores/Fever Blisters	☐ Heart Attack	☐ Mitral Valve Prolapse	☐ Venereal Disease

***If you have had any previous surgeries, list them in the area provided below. Please include the type and the year of surgery.**

PLEASE EXPLAIN ON ABOVE CHECKED ANSWERS: _____

_____

_____

_____

- Do you or have you used tobacco products? (amount and frequency) _____
- Do you consume alcohol? (amount and frequency) _____

Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

_____

_____

_____

WOMEN ONLY:

Are you currently: Pregnant or trying to conceive? _____ Nursing?_____ Taking birth control? _____

To the best of my knowledge I have answered the above information completely and accurately. I understand providing incorrect information can be dangerous to my health. I will inform the office of any changes to my health and/or medication.

Patient's Signature _____ Date:_____

Medication List

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ALLERGIES:

_____
_____
_____
_____
_____
_____

MEDICAL HISTORY:

_____
_____
_____
_____
_____
_____

Medication Name	Dosage	Frequency	DX/Indication

Preferred Pharmacy: _____

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

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_____