Marla H. Wohlman, M.D.

3351 Main Street ● P.O. Box 589
Millbrook, AL 36054
334-285-7808

Account No.

PLEASE PRINT **ANNUAL FEMALE PATIENT REGISTRATION**

PATIENT

Last Name	First	Middle	Marital Status: M / S / D
Street Address	Email Address	Cell Phone	Cell Phone Carrier
City	State	Zip Code	Home Phone
Employed By	Address		Work Phone
Sex / Date of Birth Mo / Day / Year	Social Security No.	Driver's License No.	State Issued
Spouse's Name		Spouse's Social Security No.	
Spouse's Employer	Address	Spouse's Employer Telephone No.	
Nearest Friend or Relative Not Residing With You		Relationship to Patient	Telephone No.

How Did You Learn About Us?
☐ Community Reputation ☐ Friend ☐ Yellow Pages ☐ Internet ☐ Magazine
☐ Television ☐ Another Patient ☐ Physician ☐ Newspaper Other______________

INSURANCE

Please Check: ☐ Medicare ☐ Health Choice ☐ United ☐ Other
☐ BCBS ☐ Aetna ☐ Tricare What is your Copay/Deductible?

Insurance Company Name (Primary)	Insurance Company Address			
Policy Holder	Date of Birth Mo / Day / Year	Sex	Policy Number	Group Number
Insurance Company Name (Secondary)	Insurance Company Address			
Policy Holder	Date of Birth Mo / Day / Year	Sex	Policy Number	Group Number

RESPONSIBLE PARTY

COMPLETE THIS SECTION IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE

Last Name	First	Middle	Date of Birth Mo / Day / Year	Relationship to Patient
Street Address			Social Security No.	Driver's License No.
City	State	Zip Code	Home Telephone No.	
Employed By			Business Telephone No.	

PLEASE READ BEFORE SIGNING

GUARANTEE OF ACCOUNT

THE GUARANTOR IS RESPONSIBLE FOR PAYMENT OF ALL CHARGES HEREAFTER INCURRED BY THE GUARANTOR AND THE GUARANTOR'S FAMILY. If insurance is filed by Dr. Wohlman the Guarantor is responsible for the insurance payment and any remaining balance. If we do not file insurance Guarantor is responsible for payment of charges at time of service. Any balance of 30 days past due will be charged an annual fee of 21%. Any charges not paid within 90 days will be turned over to our collection agency. Any cost incurred by Dr. Wohlman through collection, attorney fees, and court costs will be the responsibility of the Guarantor and the Guarantor will hereby waive the rights of exemption under the law of the state of Alabama and any other state. Any services rendered after an account has been turned over to our collection agency will be on a cash basis only. I agree to keep Dr. Wohlman advised on any change of address or any other change in the information furnished. I authorize the release of any credit information including but not limited to verification of employment and income as needed by Dr. Wohlman and/or her agents.

Authorization: I or we hereby authorize Dr. Wohlman and the Medical Staff to perform such Medical and Surgical procedures as are necessary and to release records as needed for received treatment. I acknowledge that no guarantees have been made as to the effect of such treatment.

______________________________ ______________________________
Signature of Patient or Legal Guardian Date

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MEDICAL RELEASE FORM

Effective April 13, 2003 (due to federal guidelines under HIPAA) we are now required to have a release form signed by the patient before we can give out any medical or financial information to any person other than the patient.

Please list below the names, relationship, and phone numbers of any authorized individuals (spouse, family members, friends, care givers, etc.) with which we may discuss your medical or financial information.

Name	Relationship	Phone Number
1.		
2.		
3.		

May we leave medical information on your "home" answering machine? Yes_________ No_________

____
Signature of Patient/Parent Date

OR

If you do not want any of your medical or financial information discussed with anyone other than yourself please sign here:

____
Signature of Patient/Parent Date

The above information is private and confidential and will be placed in your medical chart. The information on this form will remain valid until we are notified otherwise.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly
- Obtain payment form third-party payers
- Conduct normal health care operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Patient Name:____ Relationship to Patient:________________________

Signature:____ Date:_______________________________________

PHONE/EMAIL CONTACT AUTHORIZATION
MARLA H. WOHLMAN, M.D.

Your signature authorizes Marla H. Wohlman, M.D. to disclose your personal health and financial information in the following manner.

Voice mail Yes No Phone# ____

Email Yes No email address ____

Please list names of the individuals with whom we may discuss your medical information:

Name: ____ Relationship to Patient: ______________________________

Name: ____ Relationship to Patient: ______________________________

I understand I may revoke this authorization by contacting Marla H. Wohlman, M.D. in writing.

Patient Name: _____________________________________ Signature:____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented: Date__________________ Initials__________Reason______________________________

Marla H. Wohlman, M.D., P.C. Office Policy

Welcome to our practice! We are dedicated to performing high quality patient care using the latest technology advancements in a caring and friendly environment; providing our patients with a positive experience. We thank you for choosing to be part of our medical practice.

APPOINTMENTS

- ✓ Once an appointment is made, please remember that this time is reserved specifically for you.
- ✓ If you must change your appointment time, we kindly ask for a **48 hour notice for our Millbrook office** and a **72 hour notice for our Mountain Brook office** on any cancellation or rescheduled appointment.
- ✓ We reserve the right to assess a fee for the time reserved if appointments are not cancelled or rescheduled as previously stated. **This fee can range from a minimum of $50.00 to $125.00.**

INSURANCE ($15 fee for completion of all Insurance forms, effective January 4, 2012**)**

- ✓ If your insurance coverage is accepted here, the office of **Marla H. Wohlman, M.D.** will file your claims as a courtesy to you.
- ✓ Please be aware that all professional services rendered are charged directly to the Patient/Responsible Party. The Patient/Responsible Party is personally responsible for payment of fees.
- ✓ We DO NOT render our service on the basis that insurance companies will pay all of our fees.
- ✓ All patient co-pays and deductibles required by specific insurance coverage are due and payable at the time of EACH VISIT.
- ✓ You are responsible for providing us with accurate insurance information at the time of service. Failure to do so could result in your claim being rejected or delayed. Repeated filing of duplicate insurance claims due to inaccurate or inadequate information provided by you may be subject to a re-filing fee of $15.00.
- ✓ If payment of your claim has not been received within 45 days from the time the claim was filed to your insurance company, you, the patient/responsible party, will be responsible for any unpaid balance.
- ✓ If your insurance company pays less than the estimated benefit, you will be responsible for the remaining balance.
- ✓ If your insurance company pays more than the estimated benefit, you may have a credit balance on your account. Per your request, you may leave the credit on your account to be applied to charges for future care, or you may request a refund.

PRESCRIPTIONS

- ✓ **48-72 hour turnaround for maintenance medication refills.** Please refill ***ALL*** prescription medications during your office visit. Failing to request your medications at your appointment will result in a charge of $20, AND you may be required to pick up your written prescription from our office on the ***next business day*.** (effective June 1, 2013)

PAYMENT AGREEMENT

- ✓ For and in consideration of the provisions of services, I accept the fee charges as lawful debt and promise to pay said fee in full for all services at the time services are rendered.
- ✓ We accept cash, personal check, MasterCard, Visa, American Express, or Discover Card. We do not accept post-dated checks.
- ✓ In the event payment is not received by the agreed upon dates, I understand that my account may be subject to a 1 ½ % charge (21% APR) and that I may also be responsible for a $10.00 monthly rebilling fee.

COLLECTION

- ✓ **Marla H. Wohlman, M.D., P.C.** reserves the right to assess a service charge of $40.00 for all returned checks.
- ✓ **Marla H. Wohlman, M.D., P.C.** reserves the right to forward any and all accounts over 90 days past due to an outside collections agency.
- ✓ I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.
- ✓ You agree, in order for us to service your account or to collect monies you may owe **Marla H. Wohlman, M.D., P.C.**, and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.
- ✓ I waive all rights of exemption under the Constitution and laws of the State of Alabama.
- ✓ I further authorize **Marla H. Wohlman, M.D., P.C.** to receive and exchange my credit information.

I, ___________________________________, further agree to accept and adhere to the above office policy of **Marla H. Wohlman, M.D., P.C.**

Please print your name legibly

Patient, Parent, or Guardian Signature:____ Today's Date:__________________