Marla H. Wohlman, M.D.

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

Account No.

PLEASE PRINT **MALE 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 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_____

mhw/2016

Marla H. Wohlman, M.D.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, or paper, or orally, are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders of information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to a reasonable request to receive confidential communication of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information

- The right to obtain, and we have the obligation to provide to you, a paper copy of this notice from us at your first office visit.

- The right to receive, and we are obligated to obtain, a written acknowledgment that you have received a copy of our Notice of Privacy Practices.

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

Patient, Parent, or Guardian Signature:_____ Today's Date:_____

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Please return your form to the Doctor when you have finished. The Doctor will meet with you to review your information.

1. Patient Information Today's Date _____

Name _____ Birth Date _____

Address _____ City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____ Email _____

☐ MALE ☐ FEMALE Height _____ Weight _____

2. Lifestyle Information	Do you use?		If YES, how often and how much?
Tobacco (smoke, chew, dip)	YES ☐	NO ☐	
Alcohol (beer, wine, hard liquor)	YES ☐	NO ☐	
Caffeine (cola drinks, tea, coffee)	YES ☐	NO ☐	

IMPAIRMENTS: Check if you experience any of the following:

☐ Physical Impairment ☐ Visual Impairment ☐ Hearing Impairment

EXERCISE: Do you exercise regularly? YES ☐ NO ☐ If YES, describe what you do and how often.

_____

_____

_____

STRESS MANAGEMENT: Do you practice any stress management techniques? YES ☐ NO ☐

If YES, describe what you do and how often. _____

_____

_____

DIET: Describe your typical daily food intake.

First Meal	Second Meal	Third Meal	Any Snacks

3. Doctor Information: Are you currently under the care of a physician? YES ☐ NO ☐

If YES, please list each doctor from whom you seek care, including address and phone number, if you know it.

Doctor Name_____ Address_____ Phone_____

Doctor Name_____ Address_____ Phone_____

Doctor Name_____ Address_____ Phone_____

Patient Name:_____ SS#_____

4. Allergies: Please check all that apply.

_____ Penicillin	_____ Morphine	_____ dye allergies	_____ pet allergies
_____ Codeine	_____ aspirin	_____ nitrate allergy	_____ seasonal (pollen)
_____ Sulfa drug	_____ food allergies	_____ no known allergies	Other _____

---

5. Over-the-counter (OTC) issues:
Please check all products that you use occasionally or regularly. Check all that apply.

_____ Pain reliever
_____ Aspirin
_____ Acetaminophen (example: Tylenol®)
_____ Ibuprofen (example: Motrin IB®)
_____ Naproxen Sodium (example: Aleve®)
_____ Ketoprofen (example: Orudis KT®)
_____ Cough Suppressant (example: Robitussin DM®)
_____ Antihistamine product (example: Chlor-Trimeton®)
_____ Decongestant product (example: Sudafed®)
_____ Combination product (cough-cold reliever – example: TriamicDM®)
_____ Sleep aids (examples: Execdrin PM®, Unisom®, Sominex®, Nytol®)
_____ Antidiarrheals (examples: Imodium®, Pepto Bismol®, Kaopectate®)
_____ Laxatives/stool softeners (examples: Doxidan®, Correctol®)
_____ Diet Aids/weight loss products (example: Dexatrim®)
_____ Antacids (examples: Maalox®, Mylanta®)
_____ Acid blockers (examples: Tagamet HB®, Pepcid AC®, Zantac 75®)
_____ Other (please list)_____

NUTRITIONAL/NATURAL SUPPLEMENTS: Please identify and list the products you are using.

_____ Vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)_____

_____ Minerals (examples: Calcium, Magnesium, Chromium, colloidal minerals, various single minerals)_____

_____ Herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)_____

_____ Enzymes (examples: digestive formulas, Bean-Zymn B, Bromelain, CoEnzyme Q10, etc.)_____

_____ Nutrition/protein supplements (examples: shark cartilage, protein powders, amino acids, fish oils, etc.)_____

_____ Others: (glucosamine, etc..)_____

6. Medical Conditions/Diseases: Please check all that apply to you.

_____ Heart disease (example: Congestive Heart Failure)
_____ High cholesterol or lipids (examples: Hyperlipidemia)
_____ High blood pressure (example: Hypertension)
_____ Cancer
_____ Ulcers (stomach, esophagus)
_____ Thyroid disease
_____ Hormonal related issues
_____ Blood clotting problems
_____ Lung Condition (examples: asthma, emphysema, COPD)
_____ Diabetes
_____ Arthritis or joint problems
_____ Depression
_____ Epilepsy
_____ Headaches/migranes
_____ Eye disease (glaucoma, etc.)
_____ Other (please list)_____

7. Prescription Medications: Please list all prescription medications you are currently using. Be sure to include all mail order or physician samples. You may write on the back of this sheet if you need more space.

Medication Name	Dose	How many times per day?	Doctor
1.			
2.			
3.			
4.			
5.			

Patient Name:_____ SS#_____

1. How did you arrive at the decision to consider Prescription Bioidentical Hormone Replacement Therapy (BHRT)?

_____ Doctor _____ Self _____ Friend/family member

2. Bone size: _____ Small _____ Medium _____ Large

3. Body type: _____ Androgenic (male) _____ Estrogenic (female)

4. Were you prematurely gray? _____ No _____ Yes

Patient Name:_____ SS#_____

Male Hormone Replacement Therapy Patient Symptom Questionnaire

Rate the following as they apply to you. Use numbers 1-4 with 1 being Rare and 4 being Severe.

	RARE	MILD	FREQUENT	SEVERE
Fatigue, tiredness or loss of energy	1	2	3	4
Decrease in physical stamina	1	2	3	4
Feelings of depression – a sense that work, marriage or recreational activities have lost significance	1	2	3	4
Are you erections less strong	1	2	3	4
Decreased libido – less sex drive	1	2	3	4
Loss of early morning erection	1	2	3	4
Dry skin on face and hands	1	2	3	4
Increase in waist size – weight gain, especially around midsection	1	2	3	4
Increased fat distribution in chest area or hips	1	2	3	4
Feeling burned out, loss of motivation	1	2	3	4
Increase in aches, joint and muscle pains or arthritis	1	2	3	4
Frequent use of alcohol – now or in the past	1	2	3	4
Increased irritability, anger or bad temper or sadness or good mood swings (circle all that apply)	1	2	3	4
Decrease in muscle mass	1	2	3	4
The age you are_____				
The age you feel_____				
Have you lost height	1	2	3	4
Have you noticed a recent deterioration in your work performance	1	2	3	4
Sleep disruptions	1	2	3	4
Nervousness	1	2	3	4
Hot flashes	1	2	3	4
Loss of recent memory	1	2	3	4
Hair loss	1	2	3	4
Other:_____	1	2	3	4
Other:_____	1	2	3	4

Patient Name:_____ SS#_____

mhw/2016

Date_____

MARLA H. WOHLMAN, M.D.

MEDICAL SPA SERVICES – PATIENT QUESTIONNAIRE

Patient Name:_____ M___ F___ Date of Birth:_____

Cell Phone:_____ Home Phone:_____email:_____

1. Please circle the areas of your skin that concern you.

Hyperpigmentation (brown spots) Hypopigmentation (white spots) Fine lines/Wrinkles Acne

Congested Pores (blackheads) Broken Capillaries/Facial Veins Rough Skin Texture

Poor Elasticity/Thin Skin Photoaged/Photodamaged Skin (sun-damaged) Dry/Dehydrated Skin

Rosacea (red, inflamed skin)

2. What skincare system do you currently use for your body?_____

3. What skincare system do you currently use for your face?_____

4. Have you ever undergone a chemical facial peel?_____ If so, when and where was the last treatment performed?_____

5. Have you ever undergone any Laser Facial Resurfacing?_____ If so, when and where was the last treatment performed?_____

6. Have you been treated with Botox Cosmetic?___ If so, please indicate the treatment date(s)_____ _____ Area(s) treated_____

Please list any complications post injection that Dr. Wohlman needs to be aware of?_____

_____

7. Have you been treated with an Injectable Dermal Filler (s)?_____ If so, please indicate treatment date(s)_____ Area(s) treated_____

Please list any complications other than mild redness and inflammation that Dr. Wohlman needs to be aware of?_____

___

8. Do you smoke?_____ If so, please indicate the amount smoked per day._____

9. Do you frequent Tanning Bed Salons?_____ If so, how often?_____

10. Have you ever had skin cancer?_____ If so, when and what kind?_____

_____

This practice offers many services to help in achieving the goal of a more youthful you. Please mention any other areas of concern that have not been listed above. Dr. Marla Wohlman will be happy to discuss any treatment options that are available with you during your initial visit.

Please circle all treatments that interest you:

Facials Chemical Peels Massage Microdermabrasion Body Treatments Skin Tightening

Botox Restylane Juvederm Radiesse Cellulite Treatment Laser Hair Removal

Laser Skin Rejuvenation Spider Vein Treatment Active Acne Treatment/Acne Scarring

To better assist Dr. Marla Wohlman in choosing which facial products(s) and/or procedure(s) that are best suited for you, please indicate your area(s) of interest and/or concern by circling from the list below:

A. Forehead, Brow Area, Crow's Feet (small expression lines around the eyes)
B. Nasolabial Folds – referred to as Smile lines (lines that run from the nose to the corners of the mouth).
C. Oral Commissures, also known as ("marionette lines" – the lines that drop beneath the corners of the mouth.
D. Vertical Lip Lines – referred to as "smoker's" creases that run vertically above and below your lips.
E. Lip Augmentation – available for individuals that wish to achieve a fuller appearance, without the necessity of an extensive and costly surgical procedure.
F. Chin Area – subtle or deep creases within the chin, and/or a pebble-like appearance of the chin.
G. Skin Care Therapy