PATIENT DEMOGRAPHICS

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

✶**NAME:** _____ **NICKNAME (optional):** _____

✶**DATE OF BIRTH:** _____ ✶**SOCIAL SECURITY NUMBER** _____

✶**MARITAL STATUS:** (Please Circle One) Single Divorced Married Widowed

✶**RACE:**_____ ✶**ETHNICITY:**_____

✶**CURRENT ADDRESS:** _____

✶**CITY:** _____ ✶**STATE:** _____ ✶**ZIP CODE:** _____

✶**HOME PHONE NUMBER:** _____ ✶ **CELL PHONE NUMBER:** _____

✶**EMAIL ADDRESS:** _____

✶**PLACE OF EMPLOYMENT:** _____ ✶**WORK PHONE:** _____

✶Primary Insurance

INSURANCE NAME: _____

POLICY NUMBER #: _____

GROUP #: _____

POLICY HOLDER: _____

DOB: _____ **SSN:** _____

RELATIONSHIP: _____

✶ SECONDARY INSURANCE

INSURANCE NAME: _____

POLICY NUMBER: _____

GROUP #: _____

POLICY HOLDER: _____

DOB: _____ **SSN:** _____

RELATIONSHIP: _____

EMERGENCY CONTACTS WE MAY DISCUSS YOUR MEDICAL NEEDS WITH :

NAME: _____ **RELATIONSHIP:** _____ **PHONE NUMBER:** _____

NAME: _____ **RELATIONSHIP:** _____ **PHONE NUMBER:** _____

I _____ **attest that all information above is accurate and completed.**

Signature: X_____ Date: X_____

PATIENT FINANCIAL POLICY

Walter J. Lawrence, M.D., P.C.

551 Glover Ave, Enterprise, AL 36330

Phone: (334) 475-2058 Fax: (334) 489-4308

Thank you for selecting 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 staff of any concerns regarding financial limitations pertaining to your treatment plan, as there me be alternative options available.

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.

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 designated Dr. Lawrence as your primary care provider. 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.

CO-INSURANCE, DEDUCTIBLES, BALANCES: If your insurance coverage is verified and certain procedures are not covered by your insurance you will be responsible for the charges associated with this service. Balances that remain become the responsibility of 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.

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. Failure to provide 24 hours' notice of cancellation (i.e. same day cancellation or no-show) will result is a charge of **$50.00 missed appointment charge.** This charge is the responsibility of the patient and is not covered insurance carriers.

Initial Here: _____

PATIENT FINANCIAL POLICY

TERMINATION: Two unexcused appointments justify dismissal from the practice. The patient will be responsible for the No-Show (N/S) fee of a minimum of $50.00 plus up to a $40.00 Termination charge for administration fees, as well as any outstanding balance(s) on the account.

REFILLS, PRIOR AUTHORIZATIONS, REFERRALS: An administrative charge may be filed against your insurance for medication refills, prior authorizations, and referrals for the time incurred to process these requests. Please contact our office if you have any questions.

FORMS & LETTERS: Disability, Life Insurance, Formal letters, and other forms are often requested to be completed by the practice often require review by the physician and completion of a detailed medical history questionnaire. Please contact our office, with a copy of the paperwork to be completed. Please allow 3-5 days for completion of any requested forms. The charge for this service is directly dependent upon the amount of time taken in the preparation required. The fee for paperwork is $300.00 per hour, you will only be charged for the time used.

RECORDS REQUEST: Patients requesting a copy of their medical record will be charged an administrative fee. In the event you are transferring care to another provider, please have the accepting primary office send a patient signed release. Once we have received this form our office will send a courtesy copy of your record directly to the provider one time.

RETURNED CHECKS: All returned checks shall be assessed a $50.00 bank processing fee. You are responsible for this fee in addition to the owed balance on your account. Subsequent payments and balances must be paid in cash only.

COLLECTIONS: Failure to remit payment or balances due may result in the patient's account being turned over to an outside collection agency. Up to 33.33% collection fees can be assessed by the collection agency and an Administrative Fee of $30.00 will become the financial responsibility of the patient.

I hereby authorize Walter J. Lawrence, M.D., P.C., to release medical information to my Physicians and/or Insurance Company(s).

I further authorize direct payment form my insurance company(s) 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

X _____

Date

Revised Jan 02, 2025

Medical Record Release Authorization

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

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 of information will strictly be used for my treatment, which was made prior to my cancellation, in compliance with this authorization, shall not constitute a breach of my right 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 unless I revoke it in writing sooner. 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 and/or dates needed: _____
_____
_____

X _____ X _____

Patient Signature Date:

X _____ X _____

Witness: Date:

Doctor/Office to Request Records From: _____

MEDICATION LIST

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

ALLERGIES:

MEDICAL HISTORY:

Medication Name	Dosage	Frequency	Dates Medicine List Checked

Preferred Pharmacy:

Revised: May 2023

HEALTH HISTORY

Lawrence Medicine
551 Glover Ave. Enterprise AL 36330
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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:_____