Decatur Morgan
OB-GYN
Decatur Morgan Hospital

1215 7th Street SE • Suite 240 • Decatur, AL 35601
Phone: (256) 973-5216 • Fax: (256) 973-3177

New Patient Welcome Packet

Dear Patient,

Thank you for choosing Decatur Morgan OB/Gyn, we look forward to providing you with excellent care. Enclosed you will find our New Patient Forms. Please fill these out completely prior to your appointment.

At your first visit, please bring:

- Completed New Patient Forms (if you have not already submitted them to us)
- Your Photo ID
- Your Insurance Card(s)
- The bottles of all of your current medications, both prescription and over-the-counter (not just a list – please bring the bottles)
- If the patient is a minor, bring vaccination record
- You will be responsible for your co-pay at check-in

We ask that all new patients arrive at least 15 minutes early so that we can confirm your medical history information. If you are unable to submit your New Patient Paperwork prior to the day of your appointment, we require you to arrive 30 minutes early so we have time to enter and update your information before your appointment time.

The health of our patients and staff is a top priority. If you are experiencing covid type symptoms, please call the office prior to your appointment for direction on arrival. If it is a well visit or follow up, we may reschedule for a later date once your symptoms resolve.

Our waiting room is open and we ask that only the patient enter the clinic unless a visitor is needed to assist the patient, or the patient is a minor. If the patient is a minor, only one guardian may accompany them in the clinic, please no siblings unless they have an appointment as well. If you are more comfortable waiting in your car, please let us know at check in and we will call you once we have your room ready. Please wear a mask while in inside the clinic.

If you are unable to keep your appointment or need to reschedule for any reason we ask for a minimum of 24-hour notice. If you are more than 15 minutes late for your appointment, we may need to reschedule you. There is a $25 no-call, no-show fee.

Respectfully,

S. Roxanne Beck, DO, FACOG
G. Vernon Pegram III, MD, FACOG
Mishanta D. Reyes, DO, FACOG
Mitchell W. Schuster, MD, FACOG, FACS

Ashley Froscello, CRNP
Angela McLemore, CRNP
Jessica Spangler, CRNP

Office Hours: Monday-Thursday: 8:00am - 5:00pm
Friday: 8am – Noon

Practice Policies

Appointments & Procedures: We ask that you arrive on time for your appointment. If you are late for your appointment, we may have to reschedule. A $25 fee will be charged for missed clinic appointments or an appointment cancelled with less than 24-hour notice. A $100 no show fee will be charged for missed procedures and/or surgeries. Please call 256-973-5216 to notify us of needing to reschedule or cancel. After office hours, our answering service will assist you and forward your message to us the next business day.

Health Forms: We are happy to complete health forms during your appointment at no charge, if time permits. Please complete all sections designated as "patient, employee, or beneficiary". If the forms require more time we will complete after your appointment and can be picked up in 24 hours. Requests outside an office visit will be subject to a processing fee of $20 and postage fees if applicable.

Prescriptions: If you require a prescription refill outside of an appointment, please call during office hours and speak with the nurse. We do require 24 hours to call in your prescriptions or to have them ready for pick up. Prescriptions may only be picked up by the patient or person listed on the Disclosure Release. You may be required to schedule an appointment before we can issue a refill. **We do not call-in controlled substances or antibiotics without seeing you in clinic first.**

Drug Screens: If you are prescribed controlled substance medications, you may be required to provide a urine sample if required by your insurance provider. We are required to comply with all regulatory and insurance payer guidelines**.**

Pain Control: Helping you manage health conditions is important to us and we can provide mild pain relief for a short time if needed. However, we do not specialize in chronic pain management, and will refer you to a provider who does if you require long-term pain management. The decision to provide controlled substances is at the sole discretion of the Physician/Nurse Practitioner.

Dismissal: We sincerely hope that we never have to part ways, but occasionally circumstances make this necessary. If this occurs, you will be notified by certified mail and will have 30 days from that point to find another healthcare provider. During those 30 days, we will be able to offer only emergent care. We will send your records to your new provider at your request.

Financial Policies

Proof of Insurance: Please bring your current government issued photo ID and insurance card to each appointment. Delays in verification of insurance may result in you being responsible for fees and charges.

Insurance: Please be aware that knowing your insurance coverage is your responsibility including knowing which facilities and providers are covered. Please contact your insurance company for questions about your coverage.

Out of Pocket Fees: We collect co-payments at the time of service. You will be responsible for non-covered or routine charges, deductibles, and/or co-insurance amounts that apply.

Non-covered services: On occasion, a service may not be covered by your insurance. We will notify you prior to the service if we are aware and payment or a portion will be due at the time of service.

Returned Checks: There is a $40 charge for returned checks.

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Patient Information

Legal Name as it appears on your Government-Issued ID

Last Name: _____ **First Name**: _____**Middle Initial:** _____
Maiden / Other Last Name: _____**Date of Birth:** _____ / _____ / _____
Sex: ☐ M ☐ F ☐ Prefer Not to Say **Social Security Number:** _____/_____/_____
Address:

_____

City: _____ **State:** _____ **Zip:** _____
Email: _____
Cell Number: _____ **Home Number:** _____
May we contact you on your cell? ☐ Yes ☐ No

Marital Status: ☐ Divorced ☐ Life Partner ☐ Married ☐ Single ☐ Widow
Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other:
_____ **Pharmacy Preferred**_____

Emergency Contact Name: _____ **Phone Number:** _____
Relationship to Patient: _____

Employment Status: ☐Full-Time ☐Part-Time ☐Retired ☐Not Employed ☐Active Military ☐Disabled ☐Housewife ☐Self-Employed
Employer: _____**Employer Phone:** _____
Employer Address:_____
City: _____ **State:** _____ **Zip:** _____

Primary Insurance to File

Insurance Company:	Insured's Name:
Policy Number:	Insured's Date of Birth:
Group Number:	Relationship to Patient:
Insured's Social Security Number:	

Person Responsible For Account: _____**Phone:** _____

I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs and attorney's fees. I authorize Decatur Morgan Ob/Gyn to release information to insurance carriers and for insurance carriers to release information to Decatur Morgan Ob/Gyn concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignment applies.

Signature: _____ **Date:** _____

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Consent Form

Patient Name: _____ Date of Birth: _____

I authorize the release of my health information necessary to my treatment, continuity of care, and the processing of insurance claims to the following entities:

Individual Insurance Companies	Billing Services	Providers Associated with Care
Hospital Lab and Ancillary Departments	Electronic Medical Record Software Company	Agencies Associated with Care

List any person(s) who we may speak to regarding your health information or that we may obtain your health information from, including family members, relatives, significant others:

Name: _____ Relationship: _____

Phone # _____

Name: _____ Relationship: _____

Phone # _____

Name: _____ Relationship: _____

Phone # _____

Insurance release/assignment of benefit/payment authorization:
Your fee for service is due and payable by cash, check, credit card, or debit card at the time of treatment. We may not participate in all insurance plans and if your plan is one in which we do not participate, please ask for an office receipt so you can file for reimbursement if applicable. Regardless of any insurance, the guarantor listed on the Patient Information Form is responsible for his/her bill. The guarantor will also be responsible for all charges incurred by collection agencies or past due accounts.

By signing below, you are signifying that you understand and agree to the office and financial policies and the information regarding financial responsibility contained in this New Patient Packet. You are also agreeing to the release of your health information to the above listed entities for the purposes outlined and to the person(s) listed on this form. This listed of designated people can be updated at any time.

Patient/Guardian/POA Signature: _____

Date: _____ Relationship to Patient: _____

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Authorization for Release of Information

Patient Name: _____ Date of Birth: _____

Address: _____City: _____ State: _____ Zip: _____

Phone Number: _____

Guardian or POA Name: _____ Phone Number: _____

I hereby authorize* Decatur Morgan OB/Gyn *to:* _____ Release To *and/or* _____ Obtain From *the following information pertaining to my care and/or treatment:

Release To or Obtain From: Practice/Provider: _____

Address: _____

Phone Number: _____ Fax Number: _____

Include the following information:

_____ Progress Notes	_____ History & Physical	_____ Labs
_____ Immunization Records	_____ Discharge Summary	_____ Pathology Reports
_____ Referrals	_____ Imaging Reports	_____ ER Reports
_____ Entire Medical Record	_____ Other_____	

Purpose of Disclosure: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health service, and treatment for alcohol or drug abuse.

I authorize the use or disclosure of my protected health information (PHI) as described. I understand that the information I authorize a person or entity to receive may be re-disclosed and is no longer protected by federal privacy regulations.

Revocation: This authorization to release confidential information may be revoked by me, in writing, at any time, except to the extent that action has already been taken. Written revocation should be provided to the Director of Health Information Management at the above address.

I understand that authorizing the disclosure is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used on disclosure as provided in CFR 164.524. If I have questions about disclosure of my health records, I may contact the Health Information Director at 256.341.2125.

_____	_____	_____
Patient or person authorized to sign for Patient	Date	Time
_____	_____	_____
Witness	Date	Time

_____
Reason patient unable to sign

_____	_____	_____
Interpreter's Name (Please Print)	Interpretation Service (If Professional)	Interpreter's Number

_____ Refused Interpretation