Valley Women's Center

Athens-Limestone Hospital

1005 W. Market St. Ste. 17
Athens, AL 35611
Phone: 256-233-5000
Fax: 256-233-5361

Welcome to Valley Women's Center,

Please complete the attached new patient paperwork & bring it with you to your appointment.
We also ask that you bring your medications and/or a list of them, your driver's license and insurance cards, and be prepared to pay your co-payment as it is due at the time of service.

If you have any questions, please call our office during normal business hours. Hours of operation are as follows:

Monday-Thursday: 8AM-4:30PM
Monday-Thursday: Closed for lunch from 12PM-1:00PM
Friday: 8AM-12PM

We look forward to caring for you!

Valley Women's Center Staff

PATIENT INFORMATION:

First Name: _____ MI: _____ Last Name: _____

Maiden Name: (if applicable) _____ Date of Birth: _____ SSN: _____

Marital Status: (Please circle) Single Married Divorced Widowed Separated

Address: _____

City: _____ State: _____ Zip: _____

Email address: _____

Telephone (Home): (_____) _____ Telephone (Cell): (_____) _____

Telephone (Work): (_____) _____

How do you prefer to be reminded of your appointments? (Please Circle:) Phone Call Text

Race: (Please Circle:) Caucasian African American Native American Alaskan Asian Native Hawaiian Pacific Islander Decline Other: _____

Primary Language: (Please Circle:) English Spanish Other: _____

Student: (Please Circle:) Full-Time Part-Time

Employment: (Please Circle:) Full-Time Part-Time Self Employed Retired Unemployed

Employer: _____ Occupation: _____

Preferred Pharmacy: _____ Pharmacy Location: _____

Primary Care Provider: _____ Referred by: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Telephone (Primary): (_____) _____ Telephone (Secondary): (_____) _____

MEDICAL INSURANCE INFORMATION:

Primary Coverage

Insurance Company Name: _____ Copay Amount $_____

Contract Number/Member ID/Benefits Number: _____ Group Number: _____

Name of Policy Holder: _____ Date of Birth: _____

Relationship to Policy Holder: _____ SSN: _____

Secondary Coverage

Insurance Company Name: _____ Copay Amount $_____

Contract Number/Member ID/Benefits Number: _____ Group Number: _____

Name of Policy Holder: _____ Date of Birth: _____

Relationship to Policy Holder: _____ SSN: _____

OFFICE POLICIES

*Please **initial** after reading each policy:*

Initial below

- If you arrive 15 minutes after your scheduled appointment time, you will be asked to reschedule, unless prior arrangements with our office have been made. _____
- Any patient who does not cancel her appointment at least 24 hours before the scheduled time is considered a no-show. $25.00 will be charged for no-show visits and must be paid before future appointments can be scheduled. Any patient who is a no-show 5 or more times may be dismissed from the practice. _____
- All copays are due at the time of service. _____
- In the event that you establish care with a different OB/GYN physician, you will no longer be allowed to schedule an appointment with our office. This does not include a second opinion visit. _____
- Please request school or work excuses for the day of your appointment before you leave the office. _____
- Medical forms and medical record requests require a minimum of 6 – 10 business days to process. _____
- **Calls are not made notifying patients of normal results but such information will be available through the Patient Portal or over the phone if the patient chooses to call our office.** _____
- Pregnancy deductible and co-insurance payments are due no later than the 36th week of pregnancy. _____
- Picture Identification and insurance card(s) must be brought with you to all scheduled appointments. _____
- If you need a prescription refilled, please contact your pharmacy to get them to send a refill request.

Thank you for complying with our office policies. We appreciate our patients!

Signature: _____ Date: _____