

## Appointment Request Form

**A \$100.00 DEPOSIT IS REQUIRED WHEN SCHEDULING AN APPOINTMENT \***

Please select an office location for your appointment.

Dr. Almand Westbrook  
2651 Old Shell Road  
Mobile, AL 36607

Dr. Kimberly Westbrook  
101 Lottie Lane Unit 6  
Fairhope, AL 36532

Is patient currently under a physician's care for treatment of ADHD? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide the physician's name. \_\_\_\_\_

Is patient currently taking medication for treatment of ADHD? Yes \_\_\_\_\_ No \_\_\_\_\_

Were you referred to ADHD Medical Clinic by a medical professional? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide name of professional. \_\_\_\_\_

If no, how did you hear about us? \_\_\_\_\_

### Patient Information

First \_\_\_\_\_ Middle \_\_\_\_\_ Last Name \_\_\_\_\_

Preferred Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Patient Mailing Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Patient Cell Phone \_\_\_\_\_ Patient Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Primary Phone Number \_\_\_\_\_

Patient Email Address \_\_\_\_\_

### Parent/Spouse Information (if applicable)

Name of Parent/Spouse/Legal Guardian \_\_\_\_\_ Cell # \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Is address same as patient address? \_\_\_\_\_ If no, please note below.

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Email Address of individual above \_\_\_\_\_

Is the above listed parent/guardian responsible for patient account? \_\_\_\_\_

If no, please list the responsible party along with insurance information in the insurance section below.

### Patient Consent (if over the age of 18)

I give ADHD Medical Clinic of Mobile my consent to contact the individual(s) above should additional information be required to schedule my appointment. \_\_\_\_\_

Signature of Patient

Date

### Insurance Information (We do not accept Medicare or Medicaid)

Insurance Carrier \_\_\_\_\_ Contract # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Name on Card \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_\_\_

Policy Holder's Mailing Address if different than above \_\_\_\_\_

Responsible Party (yes) \_\_\_\_\_ (no) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Cell # \_\_\_\_\_

If no, please name responsible party \_\_\_\_\_ Cell # \_\_\_\_\_

**Initial \_\_\_\_\_ \*A \$100 deposit is required when scheduling a new patient appointment to hold your appointment spot. This deposit will be placed on your account as a credit to be used toward copays, case management fees, or any non-covered services. The deposit remains fully refundable until 24 hours prior to the appointment. If an appointment is missed or rescheduled within 24 hours of the appointment time, the deposit becomes non-refundable, and another deposit must be made to schedule a new appointment.**

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**Please Email Completed Form to [office@adhd-medical.com](mailto:office@adhd-medical.com)**

**Mobile (251) 243-7058**

**Fairhope (251) 990-1980**