ADHD Medical Clinic
www.ADHD-Medical.com

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.

Please Email Completed Form to office@adhd-medical.com

Mobile (251) 243-7058 **Fairhope (251) 990-1980**