Women's Birth & Wellness Center Registration Form

(Also For Use by Innovation Billing Service, Inc.)

Name: First_____ Middle Initial _____Last _____ Preferred Name: _____

Sexual assignment at birth: _____ Gender: _____ Preferred Pronouns: _____

Address _____ Apt._____ City _____ State_____ Zip Code _____

Home # (____) _____ Work # (____) _____ Cell# (____) _____ Email: _____

Date of Birth _____ SS# _____ Marital Status: S M W D Sep Eng LWP Student: F/T P/T No

Race (optional, for statistical purposes only): White (Non-Hisp.) Black (African-American) Asian Arab/Mid Eastern Hispanic Native American Pacific Islander Other: _____

In the event Women's Birth & Wellness Center's staff are unable to reach you concerning your care or treatment related to this office, may we leave a message on (please circle):
Cellular Voice Mail: Yes No Work Voice Mail: Yes No Text: Yes No
Please list the names of any person(s) to whom you give us permission to discuss anything concerning your medical status (i.e.: friend, partner, relative, spouse)
Name: _____ Phone#:_____ Name: _____ Phone#:_____
OB PATIENTS: Date of Last Period: _____ Estimated Due Date (EDD) *if known*: _____
*__Prior OB Patients:__ Have you ever had a Cesarean: Y N

Please include <u>ANY</u> and <u>ALL</u> forms of current insurance including but not limited to: personal, employer, spousal/partner, student, parental (for those under the age of 26), and government issued policies.

PRIMARY INSURANCE INFORMATION (CHOOSE ONE)

□ Blue Cross Blue Shield □ United Healthcare □ Other _____
□ North Carolina Medicaid □ Aetna
□ Cigna □ Medicare

DETAILS

Policy, Subscriber or Member # _____ Group or Account # _____

If the insurance is through another person (such as patient's husband or parent), please fill out the <u>primary cardholder's</u>:

Name_____ Date of Birth_____ SS#_____

Relationship to Patient _____ Employer _____

SECONDARY INSURANCE INFORMATION (including Medicaid/Medicare)

Insurance Name _____ Policy, Subscriber, or Member #_____ Group #_____

Primary Cardholder's Name_____ DOB_____SS#_____ Relationship_____

OR . . .

*** I DO NOT HAVE INSURANCE; I WILL BE A SELFPAY PATIENT (Initial) _____**

*** MY INSURANCE IS OUT OF NETWORK AND I WILL BE A SELFPAY PATIENT (Initial) _____**

***I HAVE INSURANCE, BUT I DO NOT HAVE MATERNITY BENEFITS & I WILL BE A SELFPAY PATIENT (Initial) _____**

***I *<u>DO NOT</u>* WANT MY INSURANCE BILLED FOR MATERNITY AND/OR SEXUAL HEALTH CHARGES (Initial) _____**

****Medishare, Samaritan, Liberty HealthShare and Christian Healthcare Ministries are treated as SELF PAY****

CONSENT

Assignment Statement: I authorize the release of any medical or other information necessary to process billing claims. I hereby authorize payment directly to Women's Birth & Wellness Center. I understand that I am financially responsible for the charges not covered. Furthermore, I request that Women's Birth & Wellness Center provide me or my aforementioned dependent with medical care. I acknowledge my responsibility to pay for that care according to the fees established. I have reviewed the Notice of Information Privacy Practices and have been offered a copy of this notice. I have had the opportunity to ask questions about the policy for protecting my confidential health information at Women's Birth and Wellness Center. We participate in an Organized Health Care Arrangement with providers in the UNC Health Alliance. We may use your PHI for our own health care operations and for those of the Organized Health Care Arrangement in which we participate. I agree to have my medical data in a de-identified format used for midwifery/birth center research. I agree to receive private health information via secure email.

PATIENT / GUARDIAN SIGNATURE_____ <u>(SEAL)</u> DATE _____

MR#_____

FINANCIAL AGREEMENT

Thank you for choosing Women's Birth & Wellness Center as your health care provider. In order to continue to provide excellent care, we have established the following financial agreement. Thank you for understanding the necessity of our policies. If you have any concerns or questions, please speak with the Business Director.

Insurance & Medicaid
We may or may not be in-network with your insurance benefits. If assignment is taken, you still will be responsible for any deductibles and copayments at the time services are rendered. Your insurance policy is a contract between you and your company; we are not party to that contract unless we also have a contract with your company. We will, however, file claims with your insurance companies. If your insurance company does not pay your claim, you will receive a bill for the balance. Please be aware that some of the services provided may be deemed non-covered services or not medically necessary under some insurance programs. We accept and file with Medicaid of North Carolina. If you are a maternity patient you will need to have active coverage under the Medicaid for Pregnant Women program. You will need to add your baby onto Medicaid or Insurance as soon as he/she is born, or the baby's bill is your out-of pocket responsibility.

Usual & Customary Rates
Our charges are based on the usual and customary rates charged by women's health care centers. Unless we are contracted with your insurance company, you are responsible for payment regardless of your company's determination of usual and customary rates.

For Maternity Patients: Please read and initial that you understand the following Advanced Beneficiary Notice.
Advanced Beneficiary Notice for Maternity Patients:

- *A $500 registration fee is due at registration (unless you have Medicaid). This fee reserves your space to give birth at Women's Birth & Wellness Center.*_____
- ***If you do not birth at Women's Birth & Wellness Center for any reason there is no refund for the registration fee**, and it will not be applied to any other outstanding fees. (This does not apply to VBAC patients).*_____
- *If you have your baby at our facility, your insurance company should process the claims. After the bith, the registration fee is applied to any remaining charges and a bill or refund is issued.*_____
- *Your insurance will be billed after the baby is born and when possible you will be issued a refund only IF the insurance company deems it as necessary.*_____
- *Self-pay clients must work with the Business Director at registration on a suitable payment contract. We offer an advanced payment discount of 10% to all self-pay patients who pay the entire fee by their 25th week of pregnancy.*_____
- *All patients are required to pay their out-of-pocket estimated cost by the 36th week of pregnancy.* _____
- *After the birth, your insurance company will be billed. Any unpaid balance will be your obligation.* _____
- *Baby charges (i.e. baby's home visit, hearing screen, and lactation counseling visits, etc.) are billed separately from parent's global bill.*_____

Maternity Self-pay Patients
If you are a self-pay patient please be aware that you are responsible for paying for your $500 deposit as well as your office visit and labs at your first visit.

Financial Hardship Policy
If you are experiencing financial hardship you may qualify for our sliding-fee scale. In order to apply for this you must submit proof of income for everyone in the household prior to your first visit. The documentation you provide must include all forms of income including child support, public assistance, unemployment compensation, and any other income you receive. Three months financial information must be submitted and must be verifiable. We also require verification of address. If you do not supply this information you cannot qualify for a sliding fee and you will be responsible for 100% of medical expenses. Please ask for an application if needed.

Missed Appointments
Please help us serve our clients better by keeping your scheduled appointments. Missed or cancelled appointments without 24-hour advanced cancellation will be charged $30.00. If your appointment is scheduled for a Monday, you must call us the Friday before your appointment.

I have read and understood the above, and agree to this financial policy.

_____**(SEAL)** _____ _____

Signature of Client **Date**

Women's Birth & Wellness Center accepts cash, checks, VISA and MasterCard. **Revised: 10/17/17**