MATERNAL-FETAL MEDICINE

Community Health Network

7120 Clearvista Drive Suite 5900 Indianapolis, IN 46256
1550 E. County Line Road Suite 301 Greenwood, IN 46227
Office (317) 621-9210 Fax (317) 621-9211

Acknowledgement of Receipt of the Notice of Privacy Practices

This is to acknowledge my receipt of this facility's "Notice of Privacy Practices".

______________________________	______________________________
Patient Name (please print)	Name and relationship of Personal Representative (if applicable)
______________________________	______________________________
Patient's Signature	Personal Representative's Signature
______________________________	______________________________
Date	Date

If mailing to individual:

Date Mailed: _____________

Address mailed to: __________________________
____
____

If emailing to individual:

Date emailed: ____________________

Email address: _____________________________________

06/07

PATIENT FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Please understand that payment for services is a part of that relationship. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

PATIENT INFORMATION:

A fully completed, current patient registration will be on file in the patient chart during the time in which the patient is considered an active patient. Patient registration will be updated by the patient yearly and will include where the patient can be reached by phone. A signature by the responsible party is required.

INSURANCE CLAIMS:

Primary Insurance: We will file claims with the patient's insurance upon the patient's submission of proof of insurance (i.e., insurance card indicating coverage, identification number and group number). In the event the patient has insurance coverage but cannot provide documentation, payment is due at the time of service. Upon receipt of the insurance card, we will submit the health insurance claim form indicating patient payment at time of service.

Secondary Insurance: Claims will be filed with secondary insurance if adequate information is received at the time of service. However, if payment is not received in our office within 45 days after filing, the responsibility will be transferred to the patient and due upon receipt.

PATIENT FINANCIAL RESPONSIBILITY:

If no insurance is to be filed by us, or if we are not a participating provider in your insurance plan, **full payment is expected.** If necessary, we can set up a payment schedule. Payment arrangements will be made with a signed Payment Agreement and the approval of the Office Manager.

Co-payments, deductibles, co-insurance and payment for non-covered services are due at the time of service. We accept cash, checks and credit cards.

MINORS/DEPENDENTS:

Children under the age of 18 will require the signature of a responsible party on the registration form.

WORKERS' COMPENSATION:

Workers' compensation will be filed if the patient notifies us when scheduling the appointment and supplies billing information at check-in. Details of the accident will be required and a workers' compensation form must be completed.

METHOD OF PAYMENT:

Acceptable methods of payment are cash, check, VISA and MasterCard. VISA and MasterCard payments can also be accepted by phone or fax.

PAST DUE ACCOUNTS:

Any outstanding balance, after insurance has paid, will be invoiced to you on a statement. Payment is due upon receipt of the statement.

Prolonged delinquency in payment may result in preparation of account for small claims court, collection agency and/or credit bureau reporting with possible discharge from the practice.

In the event an account is turned over for collection, the person financially responsible for the account will be responsible for all collection costs including reasonable attorney fees and court costs.

A patient may remit in full for all outstanding charges owed on account including amounts previously placed with the collection service. Under these circumstances, a physician may reserve the right to re-establish the patient to active status in the practice.

MISSED APPOINTMENTS:

We request the courtesy of a 24-hour notice of cancellation. Consecutive missed appointments without notice will be documented and may result in discharge from the practice.

Interpreter fees incurred as a result of a missed appointment or an appointment not canceled within 24 hours of the appointment time will be billed to the patient.

ACCOUNT CONSULTATION:

Physicians do not discuss financial issues. Our billing staff is trained to discuss your account and make payment arrangements. They will be happy to help you, but if you need further assistance please ask to speak with the Office Manager.

MEDICAL RECORDS:

If you need us to transfer your records to another physician, please contact the office. They will provide you with the HIPAA compliant documents.

ACKNOWLEDGMENT OF RECEIPT:

I have received a copy of the financial policy.

______________________________   ____/____/____

Signature   Date

Maternal-Fetal Medicine
Family and Medical History Questionnaire

Name______________________________ Appt. Date: __________
DOB: ______________ Age at Delivery ________ Appt. Time: __________

Please bring this form with you to your appointment

Yes	No		Comments
		1. Are you 34 years or older?	
		2. Is the father of your baby 55 yr or older?	
		3. Are you and the father of your baby blood relatives?	
		4. Have you had a stillbirth or more than one miscarriage?	
		5. Do you have diabetes? Are you insulin dependent?	
		6. Do you have seizures or epilepsy?	
		7. Do you have any other medical conditions for which you receive treatment?	
		8. What countries are your ancestors from originally? (Be specific- i.e. England, Africa, Vietnam)	Myself: ____________ Partner: ____________
		9. Are either of you Jewish or French Canadian?	
		Do you or the father of your baby	
		10. Have any birth defects, handicapping condition or disorder that might be hereditary?	
		11. Have any previous children with birth defects, handicaps or genetic diseases	
		12. Have any children who died (other than accidental)?	
		13. Have a brother, sister, or parent with a handicap, birth defect or genetic condition?	
		14. Have any uncles, aunts, cousins, grandparents, nephews, or nieces with birth defects or genetic diseases?	
		15. Know of any family member with mental retardation (even mild) or learning disabilities?	
		16. Have any family members who have had multiple miscarriages or a stillbirth?	

Please check any of the following that might be in either of your families.
Please indicate who in the family is affected.

__Anencephaly (open skull)
__Anemia
__Blindness
__Cancer
__Chromosome abnormality
__Cleft lip/palate
__Cystic Fibrosis
__Deafness
__Down syndrome
__Epilepsy or seizures
__Heart Defect
__Hemophilia (bleeding tendency)
__Huntington's disease
__Hydrocephalus (Water on the brain)
__Birth defects not listed above

__ Kidney disease (ie. Polycystic kidney)
___Limb defects
___Mental illness
___Mental Retardation
___Muscular dystrophy/Myotonic dystrophy
___Neurofibromatosis
___Neurologic or degenerative disorder
___Phenylketonuria (PKU)
___Sickle cell anemia
___Skeletal problems (like easily broken bones, dwarfism)
___Skin disease (including dark or light patches of skin)
___Spina bifida (open spine)
___Thalessemia (Mediterranean anemia)
___Urinary tract disease
___None of the above

Environmental Exposures History

Yes	No	Have You….
		1. Taken any prescription drugs or over the counter medications since becoming pregnant? Please list each one ______
		2. Had an illness or infection during pregnancy?
		3. Had a fever over 101 degrees or taken saunas/whirlpool baths during pregnancy?
		4. Had x-rays or surgery since becoming pregnant?
		5. Had alcohol during your pregnancy? How much ______
		6. Smoked cigarettes during your pregnancy? How many? ______
		7. Used any other drugs during your pregnancy? ______

Please list any specific questions that you would like addressed at your visit:

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ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

* **Patient Name**: (Last)________________________ (First)__________________ (MI)_____
* **DOB:**__________ * **SSN** ________________ ***Race:**____ * **Marital Status:** (M)__ (S)__ (D)__(W)__ (O)__
* Address:____________________________City__________________State________Zip_________
* **Home Phone: (__)** _________ * **Work (__)** __________ * **Cell (__)** __________ **Other (__)** _________

*******Please circle preferred phone number above to be contacted by**********

* **Employment:** ________________________ **Address:** ____
* **Referring Physician:**________________________ **Address:**____________________ **Phone: (   )** ________
* **Family Physician:** __________________ **Address:**__________________________ **Phone: (_)** __________
* **Spouse/Partner:**_____________________**Employer:**__________________**Contact Phone #: (   )**_________

* **Emergency contact person:** ______________________________
* **Relationship to Patient**____________ **Phone: (___)** ___________________

**********INSURANCE INFORMATION**********

* **PRIMARY Insurance Name:** _________________________________ **Phone #: (___)** ________________
Address:____
* **ID#**__________________________ **Group#**____________________ **Group Name:**_________________
* **Subscriber Name:**______________________________________ * **Relationship to Patient:**______________
* **DOB:**_________________ * **SSN:**_________________________ **Employer**__________________________

SECONDARY Insurance Name:________________________________ **Phone: (___)** _________________
Address:____
ID#__________________________ **Group#**______________________ **Group Name:**_________________
Subscriber Name:______________________________________ **Relationship to Patient:**______________
DOB:_________________ **SSN:**_________________________ **Employer**_________________________

* I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).

* I authorize my insurance carrier to release information regarding my coverage to Maternal-Fetal Medicine. I also authorize agents of any hospital, treatment center or previous physicians to furnish MFM copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within MFM.

* My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to MFM. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to MFM.

* I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payers; (b) governmental bodies (such as the Food and Drug Administration and the Health Care Financing Administration); (c) representatives and agents of my health benefit plan; (d) persons conducting quality or peer review or patient satisfaction surveys; and (e) other clinical and non-clinical parties that have *a* contractual relationship with Maternal-Fetal Medicine.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read the above statements and accept the terms. A duplicate of the statement is considered the same as original.

** **Patient Signature**: ______________________________________ ** **Date** : _______________

** **Responsible Party Signature:**________________________ ** **Relationship:**________________ ** **Date:**______________

Patient Medical Record Number ______________________________ Employee Initials ______________________________

02/09