

# Women's Birth & Wellness Center

## Client Registration Form

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

Name: First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last \_\_\_\_\_ Preferred Name: \_\_\_\_\_

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):

Home Answering Machine: Yes No Work Voice Mail: Yes No Cellular Voice Mail: 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: \_\_\_\_\_

### MEDICAID/MEDICARE INFORMATION

Medicaid # \_\_\_\_\_ Claims Address \_\_\_\_\_

Medicare # \_\_\_\_\_ Claims Address \_\_\_\_\_

### PRIMARY INSURANCE INFORMATION

#### COMPANY (CHOOSE ONE)

State Employees Insurance (BC/BS) P.O. Box 30025, Durham, NC 27702-3025

Blue Cross Blue Shield of North Carolina P.O. Box 35 Durham, NC 27702-0035

Other Insurance \_\_\_\_\_ Specific Plan Name \_\_\_\_\_

Insurance (1-800) Telephone # \_\_\_\_\_

"Submit Claims To" Address \_\_\_\_\_

#### DETAILS

Policy, Subscriber or Member # \_\_\_\_\_ Group or Account # \_\_\_\_\_

Co-pay for Office Visit \_\_\_\_\_ Deductible \_\_\_\_\_ Deductible Year Begins \_\_\_\_\_

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

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Employer \_\_\_\_\_

Home Address (if different) \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION

Insurance Name and Address \_\_\_\_\_

Primary Cardholder's Name \_\_\_\_\_ SS# \_\_\_\_\_ Policy # \_\_\_\_\_

OR ...

- I DO NOT HAVE INSURANCE; I WILL BE A SELFPAY PATIENT (Initial) \_\_\_\_\_ OR
- I HAVE INSURANCE, BUT I DO NOT HAVE MATERNITY BENEFITS (Initial) \_\_\_\_\_, AND  
(Circle One) I DO / DO NOT WANT MY INSURANCE BILLED FOR MATERNITY CHARGES.

### CONSENT

*Assignment Statement: I authorize the release of any medical or other information necessary to process this claim. 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. I agree to have my medical data in a de-identified format used for midwifery/birth center research.*

PATIENT / GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

#### FOR OFFICE USE ONLY:

TYPE OF CARE (CIRCLE ONE): OB GYN/OTHER MR# \_\_\_\_\_

# Women's Birth & Wellness Center

## FINANCIAL POLICY

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 policy. Thank you for understanding the necessity of this policy. If you have any concerns or questions, please speak with the Business Director.

### Insurance

We may or may not accept assignment of 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 from our billing service. Please be aware that some of the services provided may be deemed non-covered services or not medically necessary under some insurance programs.

### 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 Globally Billed Maternity:*

- 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 facility deposit**, 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, then after your insurance company processes claims 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 25<sup>th</sup> week of pregnancy. \_\_\_\_\_
- All patients are required to pay their out-of-pocket estimated cost by the 36<sup>th</sup> 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, etc.) are billed separately from mom's global bill. \_\_\_\_\_

### 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. Canceled mail with your address will suffice. If you do not supply this information you cannot qualify for a sliding fee. You will be responsible for 100% of medical expenses.

### 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.**

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date