TOTALCARE FOR WOMEN
A Division of Mid-Atlantic Women's Care, PLC

Steven B. Powers, M.D., F.A.C.O.G George Rector, Jr., M.D., F.A.C.O.G Paul I. Lindner, M.D., F.A.C.O.G Candice A. Geary, M.D., F.A.C.O.G
Barbara Carter, MD Paul R. Moncla, MD Laure n B. Jordan, MSN, CNM Monifa Dukes, MSN, CNM Ashley Williams, MSN, CNM

NAME:_____ **Preferred Name**:_____
Last First Middle Initial

DOB:_____ **S.S.N**:_____ **EMAIL:**_____

ADDRESS:_____

CITY:_____ **STATE**:_____ **ZIP**:_____

HOME PHONE:_____ **CELL PHONE**:_____ **WORK PHONE**:_____

MARITAL STATUS: _____ **LANGUAGE**:_____ **RACE/ETHNICITY**:_____

EMPLOYER:_____ **OCCUPATION**:_____

ADDRESS:_____
Street City State ZIP

EMERGENCY NOTIFICATION INFORMATION:
NAME:_____ RELATIONSHIP:_____ PHONE #:_____

Preferred Pharmacy Name:_____ Phone #_____
Address_____

PRIMARY INSURANCE: _____ POLICY HOLDER'S NAME: _____

POLICY NUMBER: _____ GROUP NUMBER: _____ RELATIONSHIP: _____

POLICY HOLDER'S SOCIAL SECURITY #: _____ POLICY HOLDER'S DATE OF BIRTH:_____

SECONDARY INSURANCE: _____ POLICY HOLDER'S NAME: _____

POLICY NUMBER: _____ GROUP NUMBER: _____ RELATIONSHIP: _____

POLICY HOLDER'S SOCIAL SECURITY #: _____ POLICY HOLDER'S DATE OF BIRTH:_____

THIRD INSURANCE: _____ POLICY HOLDER'S NAME: _____

POLICY NUMBER: _____ GROUP NUMBER: _____ RELATIONSHIP: _____

POLICY HOLDER'S SOCIAL SECURITY #: _____ POLICY HOLDER'S DATE OF BIRTH:_____

I am the patient or responsible party for above-mentioned patient. The personal and health insurance information above is true and accurate to the best of my knowledge.
I understand that my health insurance plan(s) may not pay for the services I receive from TotalCare For Women if I present with inaccurate, invalid or incomplete personal and/or health insurance information.
I understand that I am responsible for notifying TotalCare For Women of any changes in my personal and health insurance information. I have informed TotalCare For Women of ALL insurance plans for which I am eligible and/or a beneficiary. If my health insurance carrier(s) deny payment for any/all services I receive from TotalCare For Women because I did not provide accurate, valid or complete personal and/or health insurance information, I understand that I will be financially responsible for any/all charges due.

Print Name: _____ Relationship to patient if responsible party: _____

Patient or Responsible Party's Signature: _____ Date: _____

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HIPAA Notice of Privacy Practices
Written Acknowledgement Form

Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy.

I, _____ (Please print patient name) have been provided access to a copy of TotalCare For Women's NPP for review.

This acknowledgement form will be in effect until otherwise revoked by me in writing. I understand that I may ask questions to the Privacy Officer if I do not understand any information contained in the Notice of Privacy Practices.

I hereby consent to the release of any/all information regarding my medical history, current medical condition, current medical treatment and any/all patient account information to the individual(s) listed below: (if you would not like any information to be released please leave blank).

_____ _____
Name **Relationship**

_____ _____
Name **Relationship**

_____ _____
Name **Relationship**

_____ _____
Patient Signature **Date**

_____ _____
Witness By (STAFF) **Date**

Staff Use Only:
_____

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FINANCIAL POLICY

Thank you for choosing TotalCare For Women as your healthcare provider. We are committed to your health and well-being and want your care and treatment to be successful. Please understand that payment of your account is considered an integral part of your treatment.

All patients must complete our electronic medical record **Patient Medical History** as well as our Patient Registration Packet before seeing a provider. Please be prepared to present your insurance card **AT EVERY VISIT**. We ask that you notify us as soon as possible of any change in your insurance coverage, your home address and/or telephone numbers and any other pertinent information. We would like to keep your information as current as possible.

We are a specialist healthcare provider, therefore specialist co-payments & deductibles are due at time of service.

WE ACCEPT CASH, CHECKS, VISA and MASTERCARD

Your healthcare insurance coverage is a contract between you and your insurance company. TotalCare For Women will file your claims to your insurance carrier. Should your insurance carrier fail to make payment you will be responsible for the balance due. As providers we enter into contracts with healthcare insurance companies and are required to comply with their policies and procedures.

Our providers accept MOST(but not all) insurance plans with the exception of **Tricare Prime, some Medicare Replacement plans and OUT OF STATE Medicaid.(please check with staff if you are unsure if we accept your plan).** If your insurance plan is one which we do not accept you will be responsible for **payment in full at time of service.** We will provide you an itemized statement of charges and services provided in order for you to file a claim with your insurance carrier for reimbursement.

SELF-PAY: Payment **in full** is expected at the time of service unless arrangements have been made with our Billing Department prior to services being rendered.

PLEASE READ CAREFULLY THE FOLLOWING:

1. We will ask for your insurance card at **EVERY VISIT.** Please be prepared to present it at check-in.

2. Your insurance policy is a contract between you, your employer and the insurance company. We are **NOT** a party to that contract. Our relationship is with **YOU**, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurances and “usual and customary” charges. As your OB/GYN healthcare provider we will supply factual information to facilitate claim processing. Also please understand we may not know whether your insurance will cover your service(s) until the claim has been submitted.

3. Fees for services, which include unpaid balances, deductibles and co-payments, are due at the time of service. Unpaid balances may be subject to collection placement and collection fees. **A $35.00 service fee will be assessed for Returned Checks, regardless of the reason.**

4. All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within sixty(60) days the balance will be due in full from you. If any payment is made directly to you for services billed by TotalCare For Women you recognize an obligation to remit payment to TotalCare For Women.

5. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by TotalCare For Women, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

6. **A $25.00 charge** will be accessed to your account for failure to notify the office **24 HOURS** prior to your scheduled appointment time of your need or intent to cancel or reschedule an appointment. Messages left with our answering service less than **24 HOURS** prior to the scheduled appointment time will incur the stated **$25.00 NO-SHOW charge.**

FINANCIAL AGREEMENT

I have read, understand and agree to this financial policy. In the event of non-payment by my insurance carrier for whatever reason, I understand that I am responsible for payment of the balance owed, inclusive of all court costs and attorney fees of 33%. I authorize the release of any medical or other information necessary to process medical claims. I authorize payment of medical benefits to TotalCare For Women.

_____ _____

Patient Print Name Signature of Patient and/or Guardian Date

_____

Witnessed by (STAFF)