Wombkeepers
OBSTETRICS & GYNECOLOGY
MATERNITY WELLNESS CENTER

General Information Form

Date:

Name:	
Date of Birth:	
Age:	

Contact Information

Address:	
Home Phone:	
Cell Phone:	
Email Address:	

Employment Information

Are you employed outside the home?	**[ ] Yes [ ] No**
Employer Name:	
Position:	

Emergency Contact

Name:	**Relation:**
Phone#1	**Phone#2**

Insurance Information

Primary Insurance:	**Group#:**
Subscriber:	**Policy#:**
Subscriber SS# (req.):	**Subscriber DOB:**
Secondary Insurance:	**Group#:**
Subscriber:	**Policy#:**
Subscriber SS#:	**Subscriber DOB:**

Other

How did you hear about us?
Name of Primary Care Physician (if app):

109 Valley Rd. Montclair, NJ 07042
www.wombkeepers.com
Fax: 973-655-9665 Phone: 973-655-9662 staff@wombkeepers.com

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Patient Health Information Form #1

Date:	
Name:	DOB:

Please answer all questions that you feel comfortable answering. Other questions can be discussed privately with the doctor.

Gynecologic History

First Day of Last Period:
Are your cycles regular:
Are your cycles painful:
Normal Length of Cycles (Days of Bleeding):
Normal # of days from first day of period to first day of next:

Last Pap Smear:	Any abnormal paps? Y N
Last Mammogram:	Any abnormal mammos? Y N

Are you sexually active? Yes Never In the Past
Number of Current Partners:
Number of Lifetime Partners:
Are you sexually active with: Men Women Both
Are you using any method to prevent pregnancy? Y N
If yes, what?

Do you have any GYN problems? Yes No In the Past
Please explain:

Obstetrics History

Please List all Pregnancies, Including Miscarriages, Losses, and Terminations of Pregnancy

Year	Type (Vaginal, Cesarean, Miscarriage, Termination)	Weeks Pregnant	Birth Weight	Sex

Please list any pregnancy complications:

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Patient Health Information Form #2

Name:	DOB:

General Medical History

Please list all current and past medical conditions for which you have seen a doctor

Year Began	Year Resolved	Condition

Past Surgeries/Hospitalizations

Year	Procedure or Reason For Hospitalization

Current Medications

Medication	Dose (if known)

Allergies to Medications

Medication	Reaction

Social History

Do you smoke? Y N	Drink Alcohol? Y N	Use Substances? Y N

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Patient Health Information Form #3

Name:	DOB:

Family History

Please list any medical conditions that run in your family, especially any female cancers

Relative (Indicate Maternal or Paternal)	Condition

Current Symptoms

Please circle any current symptoms you are experiencing

	Symptom
General	Weight Loss Weight Gain Fever Fatigue
Head & Eyes	Headache Vision Change Dry Eyes
Ear, Nose, Throat	Sore Throat Sinus Problems Hearing Loss Ear Pain
Cardiovascular	Chest Pain Palpitations Irregular Heart Beat Leg Swelling
Respiratory	Shortness of Breath Wheezing Cough
Gastrointestinal	Constipation Diarrhea Vomiting Indigestion Bloody Stool Fecal/Gas Incontinence Abdominal Pain Food Intolerance
Urinary	Painful Urination Urgency Frequency Incontinence Bloody Urine
Gyncologic	Abnormal Periods Pain with Intercourse Abnormal Discharge Pelvic Pain PMS Abnormal Vaginal Bleeding
Musculoskeletal	Muscle Weakness Muscle Pain Joint Pain Joint Swelling
Skin	Dryness Rash Moles Sores
Breast	Pain Discharge Lump/Mass
Endocrine	Hot flashes Heat/Cold intolerance Thyroid problem Hair Loss
Psychiatric	Depression Anxiety
Neurologic	Numbness Tingling Fainting Seizures Dizziness
Hematologic	Easy Bruising Prolonged Bleeding Enlarged Glands
Other:	

Patient Signature:	Date:
Physician Signature:	Date Reviewed:

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Obstetrics Patient Information Form

Date:	Name:	DOB:

First Day Of Last Period:
Have you seen a doctor yet in this pregnancy?
If yes, what was the due date given, if so what was it?
Any infertility treatment for this pregnancy?
Name of Co-Parent, if applicable: [ ] No Co-Parent Co-Parent is [ ] Father of baby [ ] other:
Father of Baby is your: [ ] Husband [ ] Boyfriend [ ] Life Partner [ ] Sperm Donor
Father of Baby is : [ ] involved in this pregnancy [ ] not involved in pregnancy
Co-Parent Occupation, if applicable:

Genetic Information:

Please indicate with an "X" if you, the father of the baby, or anyone in either family has any of the following conditions. If applicable, indicate who has the condition in the comment section.

	Patient	Father of Baby	Comment
Indicate age when baby will be born			
Thalessemia			
Neural Tube Defect			
Heart Defect			
Down Syndrome			
Tay-Sachs			
Canavan Disease			
Familial Dysautonomia			
Sickle Cell Anemia or Trait			
Hemophilia			
Muscular Dystrophy			
Cystic Fibrosis			
Huntington's Chorea			
Mental Retardation/Autism			
Other Genetic Disorder			
Other Birth Defect			
Recurrent Pregnancy Loss or Stillbirth			

Infection History:

Please indicate if you have had or been exposed to:

Hepatitis B/Immunized	Y	N
TB/exposed to TB	Y	N
Genital Herpes or partner with Genital Herpes	Y	N
Rash or Viral Illness since last period	Y	N
History of STD (Chlamydia, Syphilis, HIV, Gonorrhea)	Y	N
Other	Y	N

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Screening For Down Syndrome and other Chromosomal Abnormalities

Screening for Down Syndrome and other chromosomal abnormalities is available to all patients, regardless of their age or family history. Options include:

1. **First Trimester Ultrascreen** (11-13 weeks): combination of blood test and nuchal translucency ultrasound test. Detects between 85% and 90% of babies with Down Syndrome.
2. **Maternal Serum Fetal DNA sampling** (Harmony, Panaroma, or Mat21) (10 weeks on): non-invasive blood test that can detect fetal DNA in maternal serum. Detects 99% of babies with Down Syndrome and other chromosomal problems. Can also detect sex.
3. **Amniocentesis/CVS**: Offerred to women 35 y/o or over or to younger women with a high risk based upon family history, ultrascreen, or maternal serum fetal DNA sampling. These are the only diagnostic tests available to detect 100% of all babies with chromosomal problems. These tests are performed by a perinatologist and carry a risk of pregnancy loss.

These options will be discussed with you in further detail at your first visit.
You will be asked to sign below after your consultation with the doctor.

After reviewing the above screening options with my doctor,

[ ] I do not want any screening for Down Syndrome or other chromosomal abnormalities

[ ] I choose to undergo a First Trimester Ultrascreen. This will be scheduled with the Maternal and Fetal Medicine Doctor of my choosing.

[ ] I choose to undergo Maternal Fetal DNA Sampling

[ ] I plan to have an Amniocentesis or CVS. This will be further discussed and arranged with the Maternal and Fetal Medicine Doctor of my choosing.

Patient Signature:	**Date:**
Physician Signature:	**Date:**

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. IT ALSO SHOWS AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND RETAIN FOR YOUR RECORDS.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We, are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint

For more information about HIPAA or to file a complaint, contact:

The U.S. Department of Health and Human Services
Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 Tel. (202) 619-02570

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PATIENT DISCLOSURE INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request that confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual home.

I wish to be contacted in the following manner (check all that apply)

[ ] Home Phone:_____ [ ] Okay to leave message
[ ] Cell Phone: _____ [ ] Okay to leave message
[ ] Other Phone:_____ [ ] Okay to leave message

I authorize Wombkeepers Obstetrics and Gynecology to release my protected health information to the following individual:

Name:_____ Relationship:_____

HIPAA ACKNOWLEDGEMENT

With my consent, Wombkeepers may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO), as further detailed in the Notice of Privacy Practices.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Wombkeepers reserves the right to revise its Notice of Privacy Practices at anytime and patients may request to receive any revisions in person or in writing.

With my consent, Wombkeepers may call my home or other designated location and leave a message, on voice mail or in person, in reference to any items that assist in my care or as necessary for payment. Wombkeepers may also mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With my consent, Wombkeepers may E-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Wombkeepers restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Wombkeepers use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing this document I acknowledge that I have read and/or received a copy of the Wombkeepers Obstetrics and Gynecology HIPAA Notice of Privacy Practices. I have also read the contents of this form. I consent to the use and disclosure of my protected health information by Wombkeepers in order to carry out treatment, healthcare procedures and payment. I have had the opportunity to ask questions and all my questions have been answered.

Printed Name:	Signature:	Date:
Witnessed by:	Signature:	Date:

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Form A: 2018 Financial Policy for Obstetric Patients
Due at First Visit

Thank you for choosing Wombkeepers Obstetrics and Gynecology as your healthcare provider. Our office is committed to providing the highest quality service and care. We would like to help you understand your health care costs for this pregnancy and how your insurance carrier will handle claims and billing. Coordinating benefits between insurance plans is often complex.

All questions about your individual coverage should be directed to your member services department at your individual company and this phone and or address is usually located on the back of your insurance card. Our billing department will do a verification of coverage with your insurance provider around the time of your first visit FOR OUR RECORDS ONLY. It is good for you to know if there are things your policy will not cover as standard OB care and if you have any deductible to meet before they start paying your claims. Many policies, especially those purchased in open market have a $2000-4000 deductible which must be met annually before any claims are paid. You should also know that in New Jersey, Doctors have contractual agreements with major insurance companies and agree to a DISCOUNTED minimum and maximum amount for all services. We submit your claim at our cost, but are reimbursed according the agreed discounted amount. The difference we agree to is always reflected in the adjustment figure that is given back to us with your global fee claim. Then your insurance will determine if you have a portion of this due based on your policy and you will be billed that amount directly. Many times you will see our submitted amount and the amount the insurance agrees to pay on the Explanation of Benefits .INSURANCE COMPANIES MAY DENY YOUR CLAIM FOR ANY NUMBER OF REASONS, INCLUDING ANY DEMOGRAPHIC INFORMATION YOU HAVE SUPPLIED TO US. SHOULD WE BE UNABLE TO COLLECT FROM YOUR INSURANCE COMPANY, WE WILL BILL YOU FOR THE TOTAL NON ADJUSTED COST OF YOUR CARE. IT WILL THEN BE YOUR RESPONSIBILITY TO PAY YOUR BILL WITHIN THIRTY DAYS.

Take the opportunity early in your pregnancy to discuss with your member benefits all costs which will be associated with your prenatal, labor and delivery, and postpartum care. You can expect most major insurance companies to reimburse your doctor for your full care at about 50% of her submitted costs. We provide for your care all during the pregnancy without receiving our compensation and require you finalizing your bill within thirty days of the day of your birth of your child. We will submit your bills to insurance within one week from date of delivery. WE DO NOT ACCEPT PAYMENT PLANS after reconciliation of your bill. **If you know in advance you have a large deductible you will need payment arrangements you must discuss these with our Practice Manager and sign a formal agreement for these payments before your second visit with us.** We will arrange a payment structure for your portion of the bill during your pregnancy and all bills on payment plan must be settled in full prior to your 36th week visit. All final bills must be settled within 30 days after receipt, otherwise late fees and/or interest may be charged, and after 120 days any bill that remains unpaid may be sent to collection. Collections can also include cost of collections and other fees associated with the collection of payment.

Our office billing department is off site. The best way to contact our billing department is through email. Please do not call the office and leave messages for billing, Contact billing@wombkeepers.com with all questions about your bill. Please allow several days for response, as our biller is a part time employee. There is also a direct line for billing that you will be able to leave a message. You can follow the prompts on our digital phone system and be directed to our billing department with Option 7. This connects to a personal cell line so please leave messages during business hours only.

Prior to your initial visit you will visit us and receive services from Total Sono for an ultrasound that confirms your pregnancy, and also from either Quest or Lab Corp for all your prenatal blood work. These are private companies and they do their own billing. Their employees run a site office and lab within the

building. They code and manage their own billing. If you receive a bill or explanation of benefits from this company please call them with any questions, as Wombkeepers does not have access to your information for these types of bills.

YOUR INITIAL VISIT WITH DR.A OR OUR MIDWIFE MELANIE COMER:
WILL BE BILLED IMMEDIATELY TO YOUR INSURANCE
FIRST NEW PATIENT VISIT WHERE PREGNANCY IS CONFIRMED (30-45 MINUTE VISIT)

SUMMARY OF GLOBAL FEE CHARGES CONTAINED WITHIN THE GLOBAL PERIOD:
SEEN MONTHLY TO 28 WEEKS, UNLESS MULTIPLE PREGNANCY OR HIGH RISK.
SEEN BI MONTHLY TO 36 WEEKS,
SEEN WEEKLY TO 40 WEEKS.
DELIVERY (NOT INCLUDING HOSPITAL CHARGES)
POSTPARTUM HOSPITAL CARE (UNCOMPLICATED)
ONE WEEK VISIT AFTER C-SECTION TO CHECK INCISION
6 WEEK VISIT AT POSTPARTUM (15 MINUTES)

SUMMARY OF PATIENT VISITS CONSIDERED OUTSIDE GLOBAL FEE
1, BIRTH CONTROL AFTER CHILDBIRTH
2. PAP SMEARS NEEDED
3. SICK VISIT DURING PREGNANCY
4. MASTITIS DURING POSTPARTUM
5. PROBLEM VISIT DURING POSTPARTUM
6. HIGH RISK COMPLICATIONS DURING PREGNANCY
7. CIRCUMCISION of a male infant, (may or may not be covered by your insurance). Total fee is out of network for infant and total cost of $300, you will be billed directly if you elect this service. We do not bill insurance for your infant.
9. INITIAL HOSPITAL CARE AND INDUCTION may or may not be covered by your policy and if declined you will be billed but this may also be subject to co-pays and or deductibles.
10. HOSPITAL CARE OUTSIDE THE REGULAR RECOVERY PERIOD AFTER BIRTH

Concierge Fee:
FOR OBSTETRICS CARE ONLY, WOMBKEEPERS HAS A CONCIERGE FEE REQUIRED FROM ALL PATIENTS FOR SERVICES AND MATERIALS NOT REIMBURSED BY STANDARD INSURANCE POLICIES. CONCIERGE FEE FOR OBSTETRICS (ALL PATIENTS) IS $200.00 DUE AT 28 WEEKS OF PREGNANCY AND IS BILLED AT THAT TIME. THIS FEE HELPS OFFSET THE MANY ADDITIONAL ITEMS AND OR SERVICES WE PROVIDE AND THAT ARE NOT COVERED BY INSURANCE AND REQUIRED BY PATIENTS AND OR PRACTICE. YOU CAN USE PRETAX DOLLARS (hsa) TO PAY THIS PORTION OF YOUR MEDICAL CARE. THIS FEE HELPS OFFSET THE MANY COSTS INCURRED FOR YOUR CARE UP TO AND INCLUDING:

DISABILITY PAPERWORK ADMIN FEE FOR YOU AND OR FAMILY MEMBERS
ADDITIONAL TIME/ ADDITIONAL APPOINTMENTS NOT OFFSET BY INSURANCE
BOOKS AND MATERIALS FOR" BETTER LABOR AND DELIVERY"
WOMBKEEPERS PREGNANCY GUIDE
ULTRASOUNDS PERFORMED AS COURTESY OR NOT DEEMED MEDICALLY NECESSARY BY INSURANCE DONE BY OUR DOCTOR DURING ROUTINE VISITS
BIRTH PLAN/PREFERENCES REVIEW WITH STAFF AND ENTRY TO CHART AND HOSPITAL RECORDS
REFERRAL PAPERWORK TO SPECIALISTS
PRESCRIPTION FOLLOW UP FOR BREAST PUMPS
BASIC LACTATION CONSULT AND OR PHONE SUPPORT BY IBCLC TRAINED LACTATION CONSULTANT STAFF MEMBER AFTER BIRTH.
POSTPARTUM BREASTFEEDING SUPPORT GROUP AND WEIGH IN

PAPER COPIES OF MEDICAL RECORDS ON REQUEST
OFFSET COSTS FOR PRENATAL YOGA AND OTHER PROGRAMS

WELLNESS CENTER CASH SERVICES CHARGES: ADDITIONAL, A LA CARTE AND ALSO SOLD IN PACKAGES

Doula Services for Labor and Delivery (required for all V- Bac patients) $750
Birthing Journey Class for Natural Labor Comfort: $75.00
HypnoBirthing Method for Natural Labor: $300.00
BreastFeeding 101: $25 per family
Infant Massage: $120 for 5 week program
Yoga: $10 per class/ 3 for $25.00
Packages available at 20% discount. See www.wombkeepers.com for information

Guide to Understanding Insurance for Prenatal Care: Please Initial

____Global Obstetric Fee for Visits from discovery of Pregnancy through Postpartum

- It consists of three components: antepartum visits, delivery, and postpartum care. This fee is submitted to your insurance after your baby is born. For example, if you see the Doctor after your last Postpartum visit for other reasons (breast problems etc.) these would not be part of the Global fee. Co pays may apply at this time. If you are ill during your pregnancy and see the Doctor for illness or any problem visit outside of your well pregnancy visits, these office visits are outside of global fees and may require co pay.
- We only bill for indicated ultrasounds performed by our doctor...for example, to confirm pregnancy, check the baby after a bleeding episode, confirm position in the third trimester, or check fetal well being for high risk or late pregnancies. Any ultrasounds "for fun" are not billed to insurance and are covered as part of your concierge fee. Ultrasounds performed by Total Sonos or another Perinatology office may or may not be considered part of global fee and co-insurance, deductibles, and copays may apply. Please contact their offices directly for any concerns regarding billing for these ultrasounds. Of note: **YOU DO NOT NEED AN ULTRASOUND AT EACH VISIT AND OFTEN YOUR BABY'S HEARTBEAT CAN BE MONITORED BY DOPPLER, so you should expect both methods to be used.**
- The hospital, pediatrician staff, and other departments at the hospital will bill your insurance for your care while in labor and delivery and post delivery care while you are staying with them. Typically you have a 2 day stay after a vaginal birth and a four day stay if it is a surgical birth. Your baby will be a patient as well and you will see bills for the baby directly.
- **Circumcision is an additional surgical cost and our Doctor will bill for her services for this, as well as the hospital for their portion. Some insurance companies now consider this a cosmetic procedure and will NOT COVER THIS PROCEDURE. Our Doctor will bill $300 for this surgical procedure and you will be responsible for any costs not covered by your policy, up to and including the entire amount. We do not adjust this bill or agree to ADJUSTMENTS with your Insurance Provider.**
- **MOST HOSPITALS WILL HAVE RESEARCHED YOUR PLAN, AS WELL AS DEDUCTIBLE AMOUNTS FOR HOSPITALIZATION. THEY WILL ASK FOR FOR THESE FUNDS AS YOU ENTER THE HOSPITAL FOR CARE IF YOU HAVE AN OPEN DEDUCTIBLE YOU HAVE NOT FULFILLED.**
- **Inductions, Long Labors, and VBAC's may also have line item billing for additional time and or procedures. This is a modifier for the global fee which covers a low risk vaginal delivery. You may have a portion if these costs not covered at 100% by your policy and again this would be part of your personal costs not covered by health care.**

- ALL WELLNESS CENTER FEES ARE TO BE CONSIDERED CASH PAY AND ARE DUE AND PAYABLE PRIOR TO THE SERVICE. THIS INCLUDES YOGA, NATURAL CHILDBIRTH EDUCATION, BREASTFEEDING 101, DOULA SERVICES. AND OTHER PROGRAMS. There are some service codes and CAN BE SUBMITTED FOR both childbirth education and doula services for full or partial reimbursement using your FSA accounts and other insurance accounts. WOMBKEEPERS will not submit these for you but will supply forms and receipts for you. THESE SERVICES MUST BE PAID IN ADVANCE AND ARE REFUNDABLE ON A CASE BY CASE BASIS.

_____ **Patient Responsibility:** We bill your insurance as a courtesy to you, but you are responsible for all costs associated with you medical care. We do not assume the responsibility of verifying your coverage, ensuring your insurance is active throughout your pregnancy, or confirming specific benefits which may or may not be covered or change throughout the period of your care. Any costs not covered by your insurance will be billed to you directly

____Coordinating Benefits:
Each insurance carrier may take 30-40 days to process a claim. The doctor may not receive the insurance payment for many months after your treatment. You may later receive a bill for additional copayments, deductibles or co-insurances not covered by your insurance for this claim. These charges are your responsibility and are due and payable within 30 days. WE DO NOT BILL SECONDARY INSURANCE. THIS IS SOMETHING YOU WILL HAVE TO DO. Many companies want to be informed initially of all insurance claims. You should call your member services once your pregnancy is confirmed and let them know you will be an OB patient and have a pending hospitalization. YOU SHOULD ALSO DISCUSS HOW AND WHEN TO ADD THE NEW BABY TO YOUR EXISTING POLICY.

_____Additional Information For Insurance:
Some insurance plans request that the insured submit additional information for review before they will process a claim. If you do not respond to their request, the claim will be denied. It is your responsibility to provide your insurance this information. They will sometimes ask that we provide this information directly, and we will do so when asked. If you receive something asking for information that you cannot provide, please call the staff or email us at staff@wombkeepers.com

_____Lab Charges:
Wombkeepers DOES NOT bill blood work that is drawn in our office. You will get a separate bill from the lab facility (LABCORP OR QUEST) associated with our office that performs your lab work. These charges are separate from our billing. They are NOT part of the global fee. Any lab billing inquiries should be discussed directly with the lab facility. Most OB patients have several thousand dollars in blood work and lab work throughout the pregnancy. A large amount is due in early pregnancy, Again, if you have not met a deductible, you will be billed directly by the lab and you pay them directly.

_____Insurance Changes:
During your pregnancy, please notify us of any changes in your insurance carrier and present us with a CURRENT insurance card. You are responsible to contact the insurance company to verify that we are participants in your plan. If you elect to change to a plan Wombkeepers does not accept, we have a right to inform you we do not take your insurance and ask you to complete your care with another provider who will accept your coverage. Please check with us if you are considering modifying or changing insurance during your pregnancy. Please read carefully the general FINANCIAL POLICY for new patients. All services billed are your personal responsibility and if your insurance will NOT pay your claim., we will bill you directly for services you received.

_____**Late Fees:** Late charges will be added to your bill if you payment is not received in a timely fashion.

30 days: $25
60 days: $50
90 days: $100
After 120 days: You will be charged 18% interest on your account balance, which will accrued monthly, and your account may be sent to collections

_____Personal Information:
Provide us with any changes in address and phone numbers as soon as possible. If you plan a move during or soon after the birth and have not received final bills, please call and update your information so that we will not be receiving rejections based on your new demographic information which is always changed at your employer level.

I certify that I have read and understand this financial policy and that I have had the opportunity to ask questions and all questions have been answered. I agree to all terms and conditions and agree that WOMBKEEPERS may send me updated information on my account by both email, mail and by calling should I have an outstanding balance or problem with my claim.

NAME:_____

SIGNATURE:_____
DATE:_____

STAFF:_____
SIGNATURE:_____
DATE:_____

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