St.Clair
Obstetrics & Gynecology

FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Our fees are reasonable and customary in accordance with other specialists' offices. In case of financial hardship, please make financial arrangements with our billing manager prior to being seen. The following is intended to provide a clear understanding of our Financial Policy and your financial responsibility:

PAYMENTS: We accept cash, debit/credit cards and personal checks. Your co-pay, deductible, or co-insurance will be collected prior to services being rendered.

INSURANCE: Remember, your insurance is a contract between you and your insurance company. St. Clair OB-GYN is pleased to bill your insurance company directly for services rendered, but it is our policy that the patient is ultimately responsible for payment for services received from ST. Clair OB-Gyn. The Physician is not responsible for your deductibles, co-payments, co-insurance, non-covered services or services rendered without proper referral authorization, or denied services.

Please remember: **YOU MUST HAVE A CURRENT COPY OF YOUR INSURANCE CARD WITH YOU AT THE TIME OF SERVICE.**

We will not change diagnosis codes in order to get your claim paid unless it is documented in the chart, as this action is illegal. IF your insurance does not cover certain procedures or office visits, this dispute remains between you and your insurance company.

INSURANCE DEADLINES: Many insurance companies have timely filing deadlines. It is your responsibility to inform us of any changes. If we are not provided with accurate information at the time of service, you may be responsible for payment in full for all services rendered.

OUT-OF-NETWORK: It is your responsibility to know if our physician is a valid provider with your insurance company. We try to verify every patient's insurance benefits before they are seen by the doctor. If you are out of network and still want to be seen by Dr. Bailey, please be advised that you will be responsible, at the time of visit, for the full amount that your insurance does not pay.

CO-PAYMENTS: All copayments are expected at time of service and will be asked for prior to seeing the physician. Patients may be rescheduled if the co-payment is not made.

FMLA, WIC OR OTHER FORMS: There is a $15.00 administrative fee for completion of any FMLA, WIC, disability or return to work forms. Please allow a minimum of 48 hours to process your request.

RETURNED CHECK POLICY: In the event that your check is returned for insufficient or held funds, there will be a $40.00 fee along with the check balance.

COLLECTION AGENCY: Outstanding balances are due within 30 days of the statement. Balances that reach 90 days past due, will have collection process started. Should your account be sent to the collections agency, you will be financially responsible for all collection fees and legal fees our office incurs through the process utilized to collect the delinquent balance. **Please remember, your account can legally be turned to a collection agency the day it is due. We want to avoid this and are willing to make arrangements with you.**

I have read and agree to the above policy. I hereby authorize treatment of the patient named below and agree to pay all fees and charges for such treatment. Charges shown on statements are considered to be correct unless notification is received, in writing, within 30 days of statement date. I agree to pay all charges within 30 days of the statement date, unless other arrangements have been made prior to any treatment. I agree to assign my insurance benefits to St. Clair OB-Gyn therein, if applicable.

Print name: _____ Signature: _____

Date: _____

Responsible Party Name (if different than patient): _____

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PATIENT REGISTRATION FORM

Co-pay_____ Deductible_____
Co-ins _____Max out of pocket _____

PATIENT INFORMATION **(PLEASE PRINT)**

First Name: _____ Last: _____ Middle: _____
Date of Birth: _____ Social Security Number_____
Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____
Street Address _____
City _____ State _____ Zip Code _____
Employment Status: **PLEASE CIRCLE** _____ Employed Student Retired Unemployed Other _____
Employer _____ Occupation _____
PLEASE CIRCLE _____Married Divorced Widowed Never Married_____
Emergency Contact _____Relationship _____
Home Phone (_____) _____ Cell Phone (_____) _____
Pharmacy Name _____ Location _____ Phone (_____) _____

Patient Phone/ Email/ Text message Consent
It is our policy to notify you of test results and confirm appointments through email. We also offer appointment confirmation through text messaging.
Email: _____
I authorize St. Clair OB- GYN to send emails to confirm appointments, send billing statements and test results to the email address above.
Authorize Email: Yes ☐ No ☐
Cell Phone: _____
I authorize St. Clair OB-Gyn to text to the above cell phone to confirm appointments.
Authorize Texts: Yes ☐ No ☐
I Authorize St. Clair OB-Gyn to leave a detailed voicemail message on either the above cell phone or home phone regarding appointments, test results and billing.
Authorize voicemail: Yes ☐ No ☐

I give the Physician/ office staff at St. Clair OB-GYN permission to discuss my medical condition with the following individuals.

Name: _____Relationship:_____
Name: _____Relationship:_____
Name: _____Relationship:_____

Family Doctor: _____Date last seen: _____ Referring Doctor: _____
RESPONSIBLE PARTY INFORMATION (if other than self)
First Name: _____ Last Name: _____ Date of Birth: _____
Social Security Number_____ Cell Phone _____ Home Phone _____ Work Phone _____
Street Address: _____ City: _____ State: _____ Zip Code_____
Employer: _____Occupation:_____ Relationship to Patient: _____
INSURANCE INFORMATION- ----------Must provide your insurance card to the front desk at check-in----------

Insurance company _____Member ID_____ Group # _____
Secondary Insurance _____Member ID _____Group # _____

Date: _____ Signature: _____

PATIENT CONSENTS /HIPAA

PATIENT AUTHORIZATION FOR EPRESCRIBE: ePrescribing is a Physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I authorize the Physician and/ or staff of St. Clair OB-OBGYN to enroll me in the ePrescribe program.

PATIENT AUTHORIZATION FOR PHARMACY BENEFITS MANAGER: I authorize the Physician and / or staff for St. Clair OB-GYN to request and obtain my prescription medication history from other Healthcare providers, the pharmacy benefit manager and/ or any third party pharmacy payers for treatment purposes.

PATIENT AUTHORIZATION FOR PPO/HMO PATIENTS: I authorize the Physician and/ or staff of St. Clair OB-GYN to release my insurance company or its representative any information including diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I understand I that I am financially responsible for any services deemed non-covered by my insurance company.

PATIENT AUTHORIZATION FOR ALL PATIENT: I understand that I am financially responsible for services in the office and the refunds from series charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a **COLLECTION AGENCY.** Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all cost/fees relating to the collection of my **DEBT.**

SPECIAL ACCOMMODATIONS: If a patient requires accommodation for their appointment, the individual or her representative must notify St. Clair OB-GYN of the needed accommodation one week prior to the first new patient appointment. Subsequent appointments also require one weeks' notice. Under the American with Disabilities Act, "Providers are responsible for incurring all costs of providing reasonable aid and cannot pass the charge onto the patient or her insurance company". If a patient who has requested accommodations does not provide a minimum of 24 hour notice to cancel appointment or does not show to the scheduled appointment, all charges incurred by St. Clair OB-GYN is the patients responsibility.

ACHNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICES: Notice to patients: We are required to provide you with a copy of our Notice of Privacy Practices which states how we may use and/ or disclose your health information. I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE ST. CLAIR OB-GYN PRIVACY PRACTICES. THERE IS ALWAYS A COPY OF PRIVACY PRACTICES IN OUR LOBBY FOR YOU TO READ.

BY SIGNING THIS FORM I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ALL OF THE ABOVE.

PRINT: _____ **SIGN:** _____

DATE _____

Patient authorization for MEDICARE PATIENT: I authorize the Physician and /or staff of St. Clair OB_GYN to release to the Social Security Administration, Healthcare financing Administration or its intermediaries or carriers any information needed for this or any Medicare claim. I permit a copy of this Authorization to be used in place of the original request payment of medical insurance benefits either to myself or the party who may cause Medicare payment information to cross over automatically to my supplement insurer. I understand that I am financially responsible for nay services deemed non-covered by Medicare.

PRINT: _____ **SIGN** _____

DATE: _____

PATIENT INFORMATION

Our goal is to provide you with exceptional medical care and to be sure all of your health concerns are addressed during your visit. Take a moment to write down your questions or issues you would like to cover with our health care team.

PROBLEMS YOU WOULD LIKE ADDRESSED AT TODAYS VISIT: _____

_____

PLEASE LIST ALL MEDICATIONS, **DOSE, HOW OFTEN YOU TAKE THEM, TABLET OR CAPSULE**: **None:** _____

_____

_____

PLEASE LIST ALL ALLERGIES & **REACTIONS**: _____

_____

PAST SURGICAL HISTORY/**DATES**: **None**: _____

_____

_____

PAST FAMILY HISTORY **(STATE THE RELATIONSHIP WITH THEIR DIAGNOSIS)** **Unknown**: _____

_____

_____

NUMBER OF PREGNANCIES & DATES:

VAGINAL: _____ C-SECTION:_____ MISCARRIAGE: _____ TERMIINATION: _____

LAST MENSTRUAL PERIOD _____

METHOD OF BIRTH CONTROL (PLEASE SPECIFY WHICH MEDICATION YOU ARE TAKING): _____

HAS YOU SIGNIFICANT OTHER HAD A VASECTOMY? _____

SOCIAL HISTORY

Are you a smoker? _____ How many years? _____ How many per day? _____

Are you a former smoker? _____ Date you quit smoking? _____

Do you drink alcohol? _____ How often? _____

PLEASE CIRCLE SYMPTOMS THAT APPLY

CONSTITUTIONAL:

CHILLS
FEVER
WEIGHTLOSS
DECLINE IN HEALTH
WEAKNESS
FATIGUE
WEIGHT GAIN

BREASTS:

DISCHARGE
SELF- EXAMINATION
LUMPS
TENDERNESS
PAIN

PSYCHIATRIC:

BEHAVIORAL CHANGES
DISTURBING THOUGHTS
MEMORY LOSS
PSYCHIATRIC DISORDERS
DEPRESSION
EXCESSIVE STRESS
MOOD CHANGES
DISORIENTATION
HALLUCINATIONS
NERVOUSNESS

URINARY:

WAKENING TO URINATE
BURNING
FLANK PAIN
INFECTIONS
STONES
URINE ODOR
BED WETTING
DIFFICULTY STARTING STREAM
FREQUENCY
PAIN ON URINATION
URGENCY
BLOOD IN URINE
EXCESSIVE URINATION
INCONTINENCE
RETENTION
URINE DISCOLORATION

FEMALE GENITALIA:

TAKING BIRTH CONTROL
CHANGE IN PERIODS - FLOW
DIFFICULT PREGNANCY
HERNIAS
MENOPAUSE
POSTMENOPAUSAL BLEEDING
SEXUAL PROBLEMS
BLEEDING BETWEEN PERIODS
CHANGE IN PERIODS - INTERVAL
DISCHARGE
ITCHING
MENSTRUAL PAIN
RECENT PAP SMEAR
VENEREAL DISEASE
CHANGE IN PERIODS (DURATION)
FERTILITY PROBLEMS
LESIONS
PAIN ON INTERCOURSE
RECENT PREGNANCY

MEDICAL CONDITIONS:

ANEMIA
CONGESTIVE HEART FAILURE
DEMENTIA
EPILEPSY
HIV
HYPOTHYRODISM
RENAL STONE
ULCER (GI)
ANXIETY
BACK PROBLEMS
COPD
DEPRESSION
GERD
HEADACHE
MI (HEART ATTACK)
STROKE
ARTHRITIS
BREAST CANCER
CANCER
DERMATITIS
GLAUCOMA
HEPATITIS
MIGRAINE
TB
ASTHMA
CORONARY ARTERY DISEASE
CHOLESTEROL HIGH
DIABETES
GOUT
HYPERTENSION
PNEUMONIA
THYROID PROBLEMS