WELCOME TO MS MATERNAL-FETAL MEDICINE

Dear Patient,

You were referred to our office by your primary OB-GYN. You will continue to see him/her as well.

We are committed to providing quality medical care to all individuals in need of high risk obstetric health services. The following information is to assist you in obtaining the greatest benefit from your visit at the least expense.

1. We encourage you to make every effort to keep your scheduled appointments. If you need to reschedule your appointment, please call us at least 48 hours in advance. We realize that emergencies happen. In that case, please call us as soon as possible. Missing your appointment without calling us 48 hours in advance will result in a $30.00 fee that is not covered by your insurance. If you miss 3 appointments without notification, you may be dismissed from the practice and your primary OB GYN will have to call us to get you another appointment.
2. We are committed to maintaining an atmosphere of mutual respect in our office. You should expect to be treated with sensitivity and courtesy during all aspects of your care. We would like to hear from you if that is not your experience. We also expect the same from you.
3. We are available by phone to answer any questions that you might have. If we feel that your concerns are better addressed during an office visit, we will schedule that for you. During office hours, non-urgent phone calls will be answered by the end of the day. If you feel that your situation requires immediate attention, please let our receptionist know.
4. Any copayments that you owe are expected at the time of your visit. It is your responsibility to check if tests or procedures are covered by your insurance. If there are any billing questions otherwise, you may call our billing service at 601-420-0141.

I encourage you to make a list of any questions you may have. You will find we are dedicated to excellence in patient care. During your consultation we will review your medical history, perform an examination and discuss your goals for you and your baby.

We look forward to participating in your health care needs.

SIGNATURE:_____DATE:_____

Patient Authorization and Privacy Policy

Initial in each space provided:

_____ ***Authorization to Release Medical Information:*** *I hereby authorize Mississippi MFM to furnish any medical information necessary to process insurance claims. I permit a copy of this authorization to be used in place of the original.*

_____ ***Authorization to Pay Benefits to Physician:*** *I hereby assign Mississippi MFM all insurance, including Medicare and Medicaid payments otherwise payable to me for service(s) rendered, but not to exceed my indebtedness to the above. It is understood that any money received from the insurance company(s) over and above my indebtedness to the clinic will be refunded to the appropriate party (me or the insurance carrier) when my bill is paid in full.*

_____ ***Consent for Treatment:*** *The undersigned authorizes the physician assigned to furnish medical and/or surgical treatment by those means he considers necessary and proper in the treatment of the patient identified below while a patient at Mississippi MFM. This treatment may require additional diagnostic procedures including but not limited to lab tests, blood drawing for those tests and ultrasounds.*

_____ ***Clinic Payment Policy:*** *I have been provided a copy of Mississippi MFM Payment Policy to review. I have read and understand the Payment Policy and agree to these terms.*

_____ ***Medicare:*** *Mississippi MFM participates with Medicare Part B. Benefits will be assigned and paid to the provider of services. Patients will be responsible for the deductible and any co-insurance amounts not paid by supplemental policy.*

_____ ***Medicaid:*** *Mississippi MFM accepts Medicaid as a primary or secondary insurance but **does not** accept Medicaid as a secondary if policy is not active on the initial date of service. I agree that all copays and remaining balances owed after payment by my primary insurance carrier are my responsibility.*

I request that payment of authorized Medicare/Medicaid benefits be made to my physician. I authorize the holder of medical or other information about me to be released to HCFA/Division of Medicaid and its agents and any information needed to determine these benefits or the benefits payable for related services.

_____ ***Notice of Privacy Policy:*** *I* understand that a copy of Mississippi MFM Notice and Privacy Policy is available to me at any time.

_____ **Medication History:** I authorize Mississippi Maternal Fetal Medicine to obtain my electronic medication history.

I have read each of the marked statements above. I understand the contents that I have read and agree to the terms thereof.

Patient's Printed Name: _____ **Date:** _____

Patient's/Authorized Representative's Signature _____ **Date:** _____

Witness' Signature: _____ **Date:** _____

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MS MATERNAL FETAL MEDICINE *501 Marshall Street, Suite 601* Jackson, MS 39202
Ph: 601-360-5651

_____ I _____ understand that there is a $30.00 fee for any appointment not cancelled at least 48 hours in advance of the scheduled appointment. This fee is due at check-in for the next scheduled appointment and applies to all patients regardless of insurance coverage. I also understand that if I do not bring the $30.00 to my next scheduled appointment then I will need to reschedule. If your appointment is on Monday, you need to call to reschedule by Thursday afternoon.

Signature: _____ Date: _____

Mon. appt – cancel by close of business Thursday....Tue. appt – cancel by close of business Friday....
Wed. appt – cancel by close of business Monday....Thur. appt – cancel by close of business Tuesday....
Fri. appt – cancel by close of business Wednesday.

WE STRONGLY ENCOURAGE REGULAR ATTENDANCE FOR YOUR SCHEDULED APPOINTMENTS TO OPTIMIZE THE OUTCOME OF YOUR PREGNANCY.

IF YOU NEED TRANSPORTATION TO AND FROM YOUR APPOINTMENT WITH OUR OFFICE, YOU CAN CONTACT MEDICAID TRANSPORTATION TO PICK YOU UP. THEIR PHONE NUMBER IS 1-866-527-9481.

PLEASE KEEP IN MIND THAT MEDICAID TRANSPORTATION DOES REQUIRE THAT YOU CALL THEM AT LEAST 3 DAYS IN ADVANCE OF YOUR APPOINTMENT TO SCHEDULE A PICK-UP. THIS IS A FREE SERVICE PROVIDED BY MEDICAID.

PLEASE BE AWARE THAT TRANSPORTATION DIFFICULTIES ARE NOT A LEGITIMATE REASON FOR NOT SHOWING OR CALLING PRIOR TO THE TWO BUSINESS DAY REQUIREMENT FOR CANCELLING AN APPOINTMENT WITH OUR OFFICE. THERE IS A $30.00 NO SHOW FEE.