MATERNAL FETAL SPECIALISTS
412 Cambridge St.
Fredericksburg, VA 22405 Tel: 540-373-7667

PATIENT INFORMATION
(Please Print)

Name: _____ Date of Birth: _____ Age: _____
(Last) (First) (Initial)

_____ Referred By: _____
(Street) (City) (State) (Zip)

Ethnicity:
Hispanic or Latino ☐
Not Hispanic or Latino ☐
Prefer not to report ☐

Marital Status ☐S ☐M ☐D ☐W
Preferred Language: _____
Race: _____

Smoking Status:
Current Smoker ☐
Former Smoker ☐
Never Smoked ☐

Home Phone: _____ Soc. Sec.# _____
Employer: _____ Work Phone: _____
_____ Cell Phone: _____
(Street) (City) (State) (Zip)
Spouse/Partner Name _____ Date of Birth _____ Email _____
Spouse SS# _____

Emergency Contact Person: _____
(Name) (Relationship) (Phone)

Preferred Pharmacy: _____

Billing Information - Person Responsible for Paying this Bill

Name: _____ Relationship to Patient: _____
Street: _____ City/State/Zip: _____

Primary Insurance Company: _____ **Policy #:** _____ **Group #:** _____
Relationship to Patient: _____ Policy Holder: _____ DOB: _____

Secondary Insurance Company: _____ **Policy #:** _____ **Group #:** _____
Relationship to Patient: _____ Policy Holder: _____ DOB: _____

AUTHORIZATIONS

Insurance Assignment and Release
I certify that I have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to Dr. DHILLON _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Medicare/Medigap/Authorization
I request the payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____ for any services furnished to me by that provider
Name of Doctor or Clinic
To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services, my Medigap Insurer, and their agents any information needed to determine these benefits for related services.

_____ _____
Signature of Beneficiary, Guardian or Personal Representative *Date*

PATIENT NAME _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, the office of Maternal Fetal Specialists may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Maternal Fetal Specialists Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of Maternal Fetal Specialists reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Maternal Fetal Specialists practice Privacy Officer at 125 Hospital Blvd., Suite 313, Stafford, VA 22554.

With my consent, the office of Maternal Fetal Specialists may call my home or other designated location and leave a message on voice mail or in person reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, the office of Maternal Fetal Specialists may 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.

I have the right to request that the office of Maternal Fetal Specialists 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 the office of Maternal Fetal Specialists 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. If I do not sign this consent, the office of Maternal Fetal Specialists may decline to provide treatment to me.

I give my permission for my protected health information to be released to:

Name	Relationship	Date
Name	Relationship	Date
Name	Relationship	Date

DEEMED CONSENT FOR DESIGNATED BLOOD BORNE PATHOGENS CONSENT TO MEDICAL CARE AND RELEASE OF INFORMATION.

Virginia law requires health care providers to notify you that Hepatitis B and C or HIV (aids) Virus testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids. This following notice is to advise you that this is in effect at this facility.

As a health care provider under the Virginia Acts of Assembly Section 32.1-45.1, whenever any health care worker associated with or working for the practice of Maternal Fetal Specialists is directly exposed to body fluids of a patient in a manner which, according to the guidelines of the Center for Disease Control, may transmit human immunodeficiency virus or Hepatitis B and C, the practice of Maternal Fetal Specialists will proceed to test the patient through his or her physician and to the health care worker(s) who was/were exposed.

When a person is tested, we automatically test for Hepatitis B and C for the safety of all concerned.

Also . . .

I voluntarily consent to medical care in the practice of Maternal Fetal Specialists which may include examinations, tests, photographs, and treatments by doctors and the staff. No promises have been made to me as to the results of treatment or examination.

I certify that the information I have reported in regards to my insurance coverage is correct. I hereby authorize the release of pertinent information to my insurance company and any other doctors involved with my case. I authorize insurance benefits to be paid directly to this office, realizing that I am responsible to pay for any non-covered services. If my account becomes assigned to a collection agency, I agree to pay all costs of collections, including agency and attorney fees.

I have read, understand, and agree to all terms specified in the financial policy.

I acknowledge that I have received or been offered a copy of Maternal Fetal Specialists Notice of Privacy Practices.

Patient's relationship to signer: _____ Patient _____ Spouse _____ Parent _____ Other

Signed	Date
Signed	Date
Signed	Date

Maternal Fetal Specialists

CONTRACT

I authorize treatment and agree to pay all fees and charges for such treatment promptly upon presentment thereof. I acknowledge that all proceeds of insurance are assigned to this office where applicable and that this office assumes no responsibility for the collection of any proceeds of insurance. In consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay 18% interest per annum on all balances which are unpaid sixty (60) days after the services are rendered; plus attorney's fees which are hereby stipulated to be 25% of such outstanding balance whether suit is filed or not; plus court costs. If the undersigned fails to promptly pay for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned.

The undersigned understands that Medical Insurance claims may be billed by the provider, as a courtesy, if the provider participates in the patient's insurance plan, and if the patient promptly furnishes the provider with all correct insurance information. The undersigned is fully responsible for all sums due whether or not insurance coverage is available.

In the absence of prompt payment, the undersigned understands that medical, personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with the federal "Health Insurance Portability and Accountability Act."

I, the undersigned, certify that I [ ] **am** an active duty member of the U.S. Armed Forces

[ ] **am not** an active duty member of the U.S. Armed Forces

Signature _____

_____ _____

Date Responsible Party

INSURANCE WAIVER

Maternal Fetal Specialists uses only Perkin Elmer Lab/NTD for 1st trimester screening. Please check with your insurance regard the insurance participation.

Maternal Fetal Specialists will not be responsible for any upaid account balance that you may owe the lab.

Patient name_____Date_____

Patient/Guarantor_____

Dear Patients,

Maternal Fetal Specialists, pc requires 24 hours notice when canceling or rescheduling your appointment.

Please be advised that without providing the proper notice and NO SHOW a $150.00 fee will be charged to your account.

COMMUNICATIONS WITH YOU

You agree, in order for us to service our account or to collect any amounts you may owe, we, our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. You agree that we or our assignees, may for training purposes or to evaluate the quality of service, may listen to and record phone conversations you have with us and assignees third party(s).

SIGNED _____ DATE _____

HIPAA

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of MATERNAL FETAL SPECIALISTS Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of Privacy Practices.

_____ Date _____

Patient Name (Type or Print)

_____

Signature