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



(Please Print)

5514 Alma Ln, Unit 200 Springfield, VA 22151 Tel: 703-827-3379

1800 Town Center Dr., #216 Reston, VA 20190 Tel: 703-827-3379

Name of Doctor or Clinic

Name:			Date of Birth:	Age:
(Last)	(First)	(Initial)	Bate of Bittil	Age
(Street) (City)	(State)	(Zip)	Referred By:	
Ethnicity:	Marital S	tatus 🗌 S 🔲 M	$\Box D \Box W$	Smoking Status:
Hispanic or Latino □	Preferred	T .		
Not Hispanic or Latino □				
Prefer not to report \square	-			Never Smoked
Address:				
Street			City	ST Zip
Home Phone:		Cell	Phone:	
Email:				
Spouse Name:				
Email:				
Emergency Contact Perso	n:			
	(Name)		(Relationship)	(Phone)
Preferred Pharmacy:				
Billing Information - Person	on Responsible for	· Paying this Bil	1	
Name:		Relationshi	p to Patient:	
Street:				
Primary Insurance Compa	any:	Poli	cy #:	Group #:
Relationship to Patient:				
Sacandary Insurance Com	nany.	D.P	И	
Secondary Insurance Com				
Relationship to Patient:	Po	licy Holder:		DOB:
AUTHORIZATIONS				
Insurance Assignment and Release I certify that I have insurance coverage wi	th			
	N 100 100 100 100 100 100 100 100 100 10		Name of Insurance Company(ies)	
	all insurance benefits, if any, otherwise payable to m 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.	ar imaneany responsible to:	an charges whether of h	or paid by insurance, I authorize	the use of my signature on all
The above-named doctor may use my heal purpose of obtaining payment for services treatment plan is completed or one year fr	and determining insurance be	disclose such informatio enefits or the benefits pay	n to the above-named Insurance able for related services. This of	Company(ies) and their agents for the consent will end when my current
Medicare/Medigap/Authorization				

Lrequest the payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to_

Medigap Insurer, and their agents any information needed to determine these benefits for related services.

for any services furnished to me by that provider

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

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 any time. 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 S	Specialists use and disclosure of my PHI to carry out TPC).
may revoke my consent in writing except to the extent that the prac his consent, the office of Maternal Fetal Specialists may decline to p	tice has already made disclosures in reliance upon my prorovide treatment to me.	rior consent. If I do not sign
give my permission for my protected health information to b	e released to:	
Name	Relationship	Date
Name	Relationship	Date
Name	Relationship	Date
	OOD BORNE PATHOGENS CONSENT TO MEDIC EASE OF INFORMATION.	CAL CARE
Virginia law requires health care providers to notify you that Hepatiti health care worker is exposed to your blood or body fluids. This follo	s B and C or HIV (aids) Virus testing on a sample of your owing notice is to advise you that this is in effect at this fac	blood may be done if a cility.
As a health care provider under the Virginia Acts of Assembly Section practice of Maternal Fetal Specialists is directly exposed to body fluit Disease Control, may transmit human immunodeficiency virus or He patient through his or her physician and to the health care worker(s)	ids of a patient in a manner which, according to "the guide epatitis B and C, the practice of Maternal Fetal Specialists	elines of the Center for
When a person is tested, we automatically test for Hepatitis B and C	C for the safety of all concerned.	
I voluntarily consent to medical care in the practice of Maternal Feta doctors and the staff. No promises have been made to me as to the	Also al Specialists which may include examinations, tests, photeresults of treatment or examination.	tographs, and treatments by
I certify that the information I have reported in regard to my insurance insurance company and any other doctors involved with my case. It responsible to pay for any non-covered services. If my account becomincluding agency and attorney fees.	authorize insurance benefits to be paid directly to this offi	ice, realizing that I am
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	of Maternal Fetal Specialists Notice of Privacy Prac	tices.
Patient's relationship to signer:PatientSpouse	eParentOther	
Signed	Da	ate
Signed	Da	ate
Signed	Da	ate

Dear Patients,

MATERNAL FETAL SPECIALISTS, PCREQUIRES 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.

THERE WILL BE A \$25 FEE FOR INSUFFICIENT FUNDS (RETURNED CHECK) and \$ 25 FEE for CREDIT CARD CHARGE BACK (DISPUTE) & \$50 CHARGE BACK HANDLING FEE WITH REASONABLE ATTORNEY FEE.

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/artifical 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	
SIGNED	DATE	
A SPECIAL SPORT OF SECURITY		

HIPAA

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

Ihereby 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		



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 act	tive duty member of the
U.S. Arm	ed Forces
[] <u>am not</u> ar	n active duty member of the
U.S. Arm	ned Forces
Signature	
Date	Responsible Party
INSURANCE I	WAIVER
Maternal Fetal Specialists uses only Perkin Elmer Lab/N your insurance regard the in	
$\label{lem:maternal} Maternal Fetal Special ists will not be responsible for an lab.$	yunpaid account balance that you may owe the
Patient/Guarantor	Date