MAHEC

Ob/Gyn Specialists at Franklin

WELCOME TO OUR PRACTICE

Congratulations on your pregnancy and thank you for choosing MAHEC Ob/Gyn Specialists for your obstetrical care. Our staff extends our warmest welcome to you and your family.

As your healthcare provider, we are committed to providing you with the highest level of compassionate care in a comfortable, patient-centered environment. You will receive quality care from our team, which includes board certified physicians and nurse midwifes.

Your first prenatal care appointment may take several hours. Unfortunately, we do not have a childcare facility so please arrange care for small children. If you do need to bring a small child with you, please have another adult with you who can take care of them while your provider is seeing you.

OFFICE HOURS - Monday – Thursday 8:00-5:00

If you have a concern, please call (828) 547-3004. A nurse will return the call the same day, as soon as possible. If you have an emergency, please tell the receptionist when you call so that a nurse can talk with you immediately.

AFTER HOURS

Nights, weekends, and holidays a fifteen-person attending physician group covers our practice. In addition, other community physicians assist us in our coverage system. We have found this to be the safest and most effective system to serve you. One individual from this group is on duty at Mission Hospital at all times. It is helpful if you call before coming to the hospital. You may reach us call by calling our office at (828) 547-3004 and selecting option #1 for the answering service. Your call will be answered by a nurse and triaged to a physician. If you have a non-urgent issue, you can select option #2 to leave a voice mail message for us. Calls are returned the next business day.

MAHEC Ob/Gyn Specialists at Franklin
56 Medical Park Drive, Franklin, NC 28734

Phone: 828-634-4565 | **Fax:** 828-407-2593

Important Information About your First Prenatal Care Checkup

Now that you know you're expecting, it's important to take very good care of yourself and your baby. Your first prenatal checkup is usually the longest because your provider asks you many questions and does several tests.

How do you get ready for your first prenatal checkup?

You might not be sure about what to expect at this first appointment. It helps to plan ahead. At this appointment, your provider talks to you about your health. He or she may have you answer questions about your health history using a paper form and computer. This helps your provider plan the best care for you and your baby.

Be prepared to tell your provider about:

- Date of your last menstrual period (this helps your provider find out your due date)
- Ultrasounds you have already had of this pregnancy
- Health problems like diabetes, high blood pressure or sexually transmitted infections
- Past pregnancies (for example, if you had a preterm birth or miscarriage before)
- Past hospital stays
- Medicines you're taking or if you're allergic to any medicines
- Lifestyle, such as if you drink alcohol, smoke, or use street drugs
- Exercise or other activities you do
- Stress you feel
- Safety of your environment
- Family health history (talk to your family members related to you by blood to learn about any diseases or illnesses that run in your family)
- Partner's family health history

Also, keep learning about your family health history. If you learn something new, or have a question for your healthcare provider, write it down. You can talk to your provider at your next visit. These steps will help you to have a healthy pregnancy and a healthy baby.

What else happens at the first prenatal care checkup?

At your first prenatal care checkup, your provider does some tests to check your health and your baby's health.

- Checks your weight
- Takes your blood pressure
- Checks your urine for infection
- Does some blood tests to check for anemia and to see if you have certain infections (we recommend that all women are tested for HIV, the virus that causes AIDS)
- Gives you a prenatal vitamin with 600 micrograms of folic acid
- Does a full physical exam and schedules you for an ultrasound to make sure your pregnancy is off to a good start
- May do a Pap smear to check for cervical cancer and other tests for vaginal infections

Go to all your prenatal checkups, even if you're feeling fine!

All of your health information and physical exam will be done in private and kept strictly confidential. You will receive important nutrition information as well as meet our nutritionist, financial counselor and social workers.

Name: _____

DOB: _____

MRN#: _____

Who may we speak with?

This form will allow MAHEC to **discuss** your medical and financial information about the care and services you have received with individuals of your choosing. This form does not allow the listed individuals to obtain copies of your medical or financial information. **You may list up to three (3) individuals below OR choose not to list anyone. You can update this form at any time.**

Person #1 that we can speak with

Name: _____

Relationship: _____ Phone #: _____

Person #2 that we can speak with

Name: _____

Relationship: _____ Phone #: _____

Person #3 that we can speak with

Name: _____

Relationship: _____ Phone #: _____

OR

☐ I do not wish to list anyone at this time.

_____ _____

Signature of patient, parent, or legal guardian Date

MAHEC Patient Registration Form

Please complete the following information using black ink. THIS INFORMATION IS CONFIDENTIAL.

☐ Psychiatry ☐ Internal Medicine ☐ FHC Biltmore ☐ FHC Cane Creek ☐ FHC Enka/Candler ☐ FHC Newbridge ☐ Ob/Gyn Biltmore
☐ Pharmacy at Enka ☐ Pharmacy at Biltmore ☐ Ob/Gyn Franklin ☐ Women's Care Brevard ☐ Deerfield ☐ Givens

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Mailing Address: _____ Birth Sex: ☐ Male ☐ Female

City: _____ State: _____ ZIP: _____ SS#: _____

Home County: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

By providing a phone number, mobile phone number, or email address, I authorize MAHEC to contact me or my guardian/legal representative to remind me of appointments, to obtain feedback on my experience at this office, and to provide general health reminders and other information regarding my healthcare.

Special Hearing Needs:

_____ **Uses Wheelchair:** ☐ Yes ☐ No

Special Vision Needs: **Speech Impaired:** ☐ Yes ☐ No

_____ **Veteran Status:** ☐ Yes ☐ No

Race (select one):
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Guamanian/Chamorro
- ☐ Samoan
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ White
- ☐ More than one race

Ethnicity (select one):
- ☐ Mexican/Mexican American/Chicano
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Hispanic/Latino/Spanish
- ☐ Non-Hispanic/Latino/Spanish

Gender Identity:
- ☐ Male
- ☐ Female
- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Other
- ☐ Choose not to disclose

Sexual Orientation:
- ☐ Lesbian or Gay
- ☐ Heterosexual (or straight)
- ☐ Bisexual
- ☐ Something else
- ☐ Don't know
- ☐ Choose not to disclose

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ Russian
- ☐ American Sign Language
- ☐ Other: _____

Marital Status:
- ☐ Single
- ☐ In a relationship
- ☐ Partner
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Special Populations

Migratory ☐ Yes ☐ No
Seasonal ☐ Yes ☐ No
Homeless ☐ Yes ☐ No

Homeless Status (select one):
- ☐ Not Homeless
- ☐ Homeless Shelter
- ☐ Transitional
- ☐ Doubling Up
- ☐ Street
- ☐ Permanent Supportive Housing
- ☐ Other

EMERGENCY CONTACT INFORMATION

MRN #: _____

Name: _____

Relationship: _____ Phone#: _____

IF PATIENT IS CHILD (UNDER 18)

Responsible Party Name: _____

Relationship: _____ Phone#: _____

ANNUAL HOUSEHOLD INCOME BEFORE TAXES

_____ # of Individuals in Household: _____

The income information above is used for statistical information only and is not used to determine specific patient financial needs.

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Policy ID#: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Relationship to Patient: _____ Policy Holder's Birth Sex: ☐ Male ☐ Female

Policy Holder's Address: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Policy ID#: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Relationship to Patient: _____ Policy Holder's Birth Sex: ☐ Male ☐ Female

Policy Holder's Address: _____

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

I hereby authorize payment of all insurance, Medicaid, and/or Medicare benefits directly to MAHEC and I authorize them to file insurance on my behalf. I also authorize them to release medical and/or account information to my insurance, Medicaid, and/or Medicare carrier as required to satisfy claims. I agree to notify them should my coverage change.

I understand that MAHEC:

- Expects payment on the date of service (if insured, co pays and deductibles are expected on the date of service).
- Accepts cash, checks, debit cards or major credit cards.
- Expects Medicaid, Medicare and all insurance will be filed for me. However, it is my responsibility to know the details of my insurance coverage and provide MAHEC with current and accurate information.
- Will work with me to establish payment plans.
- Provides services and treatment, which are medically appropriate. However, some of these may not be covered by my insurance plan and these will be my responsibility to pay.
- Expects my insurance company to pay within 90 days from the date of service and will bill me directly if the insurance does not pay.
- Expects the parent or guardian to pay for all services rendered to their dependents.
- Expects me to keep appointments and to call at least 24 hours prior, if I need to cancel. I understand that failure to do this may result in being discharged from the practice.

I have read and understand the above.

Patient or Parent/Guardian Signature: _____ Date: _____

Note: Failure to sign does not relieve you of the above expectations.

MRN #: _____

CONSENT FOR TREATMENT

I voluntarily consent to routine services, medical treatment(s), diagnostic radiology procedure(s), diagnostic lab(s), behavioral health services, and services offered by lay health workers (e.g. doula, community health worker, peer support specialist) as deemed necessary by the healthcare providers treating me at any MAHEC facility. I voluntarily consent to allow MAHEC to seek emergency medical care from a physician or hospital, if needed. I understand that diagnostic procedures may include but are not limited to lab tests on blood, urine, and tissue, including drug screenings. I understand that diagnostic radiology procedures include but are not limited to x-ray, ultrasound, and/or mammography. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may cause injury or even death. I understand I have the right to ask questions about my treatment and/or procedures and the right to refuse any treatment or procedure. I agree to notify my provider of my concerns.

Patient or Parent/Guardian Name (please PRINT): _____

Patient or Parent/Guardian Signature: _____ Date: _____

NOTICE OF PRIVACY ACKNOWLEDGMENT

I have been given the opportunity to read MAHEC's Notice of Privacy Practices, and my questions concerning the Notice have been answered. I understand if I choose not to sign this acknowledgment, MAHEC will continue to provide services to me and will use and disclose my Protected Health Information (PHI) in accordance with MAHEC's Notice of Privacy Practices.

Patient or Parent/Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY

Primary Care Provider: _____

Copy of insurance card obtained? ☐ Yes ☐ No

SLIDING SCALE DISCOUNT PROGRAM

Compassionate financial support

It is the policy of MAHEC to provide essential services for Medical, Behavioral Health, and Dental Care regardless of the patient's ability to pay. Discounts are offered based on family size and annual income.

The discount will apply to all essential services provided and billable by MAHEC. Services performed by outside organizations and equipment that is purchased from outside companies, including outside laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services, will not be covered under this policy. This form must be completed every 12 months or if your financial situation changes.

The application can be completed online by using the QR codes below, or you can request a paper application from any front desk team member.

These documents will need to be turned in before your application can be processed: Completed Application and Proof of Income

Applications need to be received within 30 days of your first appointment.

Family Health Centers
Financial Advocate
Phone: (828) 771-5502 | Fax: (828) 579-4208

Mailing Address:
123 Hendersonville Rd, Asheville, NC 28803

Ob/Gyn Specialists
Financial Advocate
Phone: (828) 771-5443 | Fax: (828) 407-2639

Mailing Address:
119 Hendersonville Rd, Asheville, NC 28803

Center for Psychiatry and Mental Wellness
Financial Advocate
Phone: (828) 771- 5466 | Fax: (828) 579-4212

Mailing Address:
125 Hendersonville Rd, Asheville, NC 28803

Dental Health Centers
Financial Advocate
Phone: (828) 398-5918 | Fax: (828) 552-8691

Mailing Address:
123 Hendersonville Rd. Asheville, NC 28803

Internal Medicine
Financial Advocate
Phone: (828) 771-3507 | Fax: (828) 579-3748

Mailing Address:
123 Hendersonville Rd, Asheville, NC 28803

English **Español**

If you have any questions regarding this program, please feel free to contact your Patient Financial Advocate

OB/GYN Specialists Pregnancy Billing Information

Congratulations on your pregnancy and thank you for choosing MAHEC OB/GYN Specialists!

We would like to provide you with information that may be helpful regarding insurance and billing related to your pregnancy care. We participate with many insurance companies including Medicare, Medicaid, BCBS, United Healthcare, Cigna, MedCost and Crescent. Please call our billing department at 828-257-4725 if you have questions regarding your insurance.

We recommend all patients, including those that have insurance, apply for Medicaid for pregnant women. This is a specific Medicaid that has much higher income guidelines than regular Medicaid. You are allowed to have both insurance and Medicaid. If you qualify, Medicaid will cover your co-insurance and deductibles that are charged by your insurance company. You need to apply as soon as possible in order for all your visits to be covered. You will need to apply for Medicaid at the Dept. of Social Services in the county in which you live. Here are some surrounding counties phone numbers so you can get more information as to what you will need to bring with you when apply for Medicaid.

Buncombe County – 828-250-5500
Henderson County – 828-697-5500
Madison County - 828-649-2711
Yancey County - 828-682-6148
McDowell County - 652-3355
Rutherford County - 828-287-6199
Haywood County - 828-452-6620
Jackson County - 828-586-5546
Transylvania County - 828-884-3174
Polk County - 828-894-2100

Average cost for MAHEC provider services for a normal pregnancy:

Pre-natal Care, Vaginal Delivery and Post-Partum Care - $3600.00
Pre-natal Care, C-section Delivery and Post Partum Care - $4200.00

This includes your office visits with our providers, delivery of your baby and post partum visits with our providers. ***Labs, ultrasounds, non-stress tests, and other services are billed separately at the time of service.*** These services may be assessed a co-pay or deductible by your insurance company. Medicaid (primary or secondary) does not assess co-pays or deductibles on pregnancy visits. Please call Mission Hospital for information regarding your charges for your hospital stay (828-213-1500).

If you have any questions, please do not hesitate to contact MAHEC's billing office at 828-257-4725. We may have to refer you to your insurance company for specific policy questions, but we are here help with any questions you may have regarding your bill.

Again, thank you for choosing MAHEC OB/GYN Specialists for your healthcare needs!

INCOMING TO MAHEC

MAHEC

MRN: _____

Centralized Medical Records Department

121 Hendersonville Road, Asheville, NC 28803 | Business Office Phone: (828) 771-5489 | Fax: (828) 407-2637

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

Patient Name: _____Date of Birth:_____

I authorize the use or disclosure of the above named individual's health information as described below.

The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY:	MAHEC Centralized Medical Records Department ❑ Family Medicine ❑ OB/Gyn ❑ Internal Medicine ❑ Dental ❑ Psychiatry ❑ Community Pharmacy
ADDRESS:	**121 Hendersonville Road**
CITY/STATE: PHONE #: FAX #:	**Asheville, NC 28803**

The purpose or need for this disclosure is:

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 CFR Part 2), rape, abuse (sexual, physical, elder, spousal, etc.) abortion, sexual diseases like HIV/AIDS and other communicable disease and genetic testing.

Information to be disclosed: *(check appropriate box(es))*

❑ Standard release (last 3 years of notes, lab/x-ray reports, med list, allergy list, immunization record, consult notes.)

❑ Only information related to *(specify)*: _____

❑ Only the period of events from: _____ to _____

❑ Entire medical record

❑ Exclusions
- __ AIDS/HIV test results, diagnosis, treatment, and related information
- __ Drug screen results and information about drug and alcohol use and treatments
- __ Mental health notes
- __ Genetics testing

I understand that this authorization will expire 90 days from the date it is signed unless I have specified a different expiration date or expiration event as follows. _____

I understand that I may cancel this authorization at any time by notifying in writing the MAHEC Privacy Officer, 121 Hendersonville Road Asheville, NC 28803, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws.

I understand that MAHEC will not condition treatment or eligibility for care on the provision of this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

By signing below, I acknowledge that I have read and understand this Authorization.

SIGNATURE OF PATIENT	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE PATIENT, IF APPLICABLE *(State relationship to Patient)*	DATE
WITNESS TO SIGNATURE, IF APPLICABLE	DATE

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.