UnityPoint Health
Des Moines

Perinatal Center Outpatient Registration

Date: _____ Legal Name:_____ _____ _____
First MI Last

Preferred Name: _____ Maiden Name: _____

Cell Phone: (_____) _____ Home Phone: (_____) _____

Email address: _____ Employer Phone: (_____) _____

Address: _____ Apt#: _____ City: _____

State: _____ Zip Code: _____ County: _____ Birthdate: _____/_____/_____ Age: _____

Marital Status: _____ Religion: _____ SSN:_____-____-_____

Employer: _____ Occupation: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ PRN ☐ N/A ☐ Student

Primary Care Provider: _____

Please specify the race you most closely identify with: _____

Do you consider yourself to be ethnically Hispanic or Latino?: ☐ Yes ☐ No

Language Spoken: _____

Insurance Company/Cardholder's name

Primary _____ Secondary: _____

Spouse Name: _____ SSN: _____-____-_____ Birthdate: _____/_____/ _____
(Only if the insurance card holder)

Employer: _____ Employer Phone: (_____)_____

Employment Status: ☐ FT ☐ PT ☐ PRN ☐ N/A Alternate Phone:(_____)_____

Please complete if you are a minor or your insurance held by someone other than you OR your spouse:

Guarantor Name: _____ Relationship to Patient: _____

SSN: _____-___-_____ Birthdate: _____/_____/_____ Home Phone:(_____) _____

Address: _____ City: _____State: _____ Zip: _____

Employer: _____ Employment Status: ☐ FT ☐ PT ☐ PRN ☐ N/A

Perinatal Center Patient Communication Form

Name: _____ DOB: _____ Last 4 digits of SSN: _____

The purpose of this form is to obtain guidance about how we should communicate about you and to you.

SECTION 1: Communications to Family Members and Others Involved In My Healthcare

I give my permission to Perinatal Center to communicate information concerning my medical condition and medical treatment to the person(s) listed below.
(Note: If the patient is a minor, pursuant to Iowa law, information generally will be given to both parents unless Perinatal Center otherwise deem the communication inappropriate.)

Name 1: _____ Relationship: _____ Phone: _____

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I understand that it is my responsibility to update the above information if I want it changed. This communication information will be used for all medical conditions and treatment obtained at Perinatal Center or at the request of one of the healthcare providers employed at Perinatal Center. I understand that mental health, substance abuse treatment and/or HIV information may not be disclosed pursuant to this form and that a HIPAA- compliant Patient Authorization to Release Information form must be completed to disclose any mental health, substance abuse treatment and/or HIV information. Additionally, I understand that if there are exceptions to the communications permitted pursuant to this form, it is my responsibility to notify Perinatal Center.

This form does not provide the above-named person(s) with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate a health care partner or representative, or if you wish to set up a living will, please discuss this with your primary healthcare physician or your attorney.

SECTION 2: Standard Methods to Communicate to Me (the patient)

Detailed information regarding my medical condition and medical treatment may be left on:

My Home Answering Machine ☐ Yes ☐ No Home number is: _____

My Work Answering Machine ☐ Yes ☐ No Work number is: _____

My Cell Phone ☐ Yes ☐ No Cell number is: _____

Exceptions (types of information that cannot be left as messages): _____

_____

This form will be in effect until revoked, but I may be asked to confirm the information with a new dated signature on an annual basis.

Signature of Patient or Legal Guardian: _____

Date: _____ Relationship (if not patient): _____

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Perinatal Center Policies & Procedures

Policy for Arriving Late:
Appointments are scheduled at your convenience and allow our day to flow efficiently for each patient and family. If you arrive 5 minutes late for your scheduled appointment it may be necessary to reschedule your appointment.

Policy for No-Show Appointments:

To offer you the best patient care, a positive relationship and regular visits are essential. All "failed" appointments by the patient will be documented by the staff in the patient's records and will be reviewed by the providers. A patient is considered to have failed an appointment when the patient has not called or checked in within 15 minutes of appointment time. After three "no-shows or failed" appointments in a 12 month period, the providers will be given the option to terminate your care.

FMLA and Short Term Disability Paperwork:

There are no fees for filling out patient FMLA or Short Term Disability forms. Paperwork needs to be dropped off at the front desk to be processed. Please allow three to five business days for paperwork to be completed.

Insurance/Payment:

I understand that as a patient of Unity Point Health – Des Moines Perinatal Center, it is my responsibility to know my insurance plan and what benefits are covered, to know if and when a referral is necessary, and have verified that the providers here are in network with my plan. Any balance remaining after insurance has paid is my responsibility. Any questions or concerns that I may have can be addressed to the financial counselor by calling the office during business hours.

My signature below represents **I have read and understand** the statements above.

Patient's Name | Signature of Patient or Legal Guardian | Date

UnityPoint Health
Des Moines

CONSENT TO TREAT

I request and give my consent to medical care and treatment from UnityPoint Health – Des Moines providers and healthcare workers. I understand this includes and is not limited to diagnostic procedures, screening procedures, pathology services, and radiology services. I agree that photographs may be taken of me and used for my treatment or identification purposes.

FOR FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible to pay UnityPoint Health – Des Moines its usual charges for all services received through UnityPoint Health – Des Moines, including any balances not covered by my insurance carrier(s). I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to UnityPoint Health – Des Moines, and direct that payment of proceeds be made directly to UnityPoint Health – Des Moines.

RECORDS RELEASE FOR CLAIMS PAYMENT

I authorize the release of medical record information or excerpts thereof to any insurance company or third party payer for utilization management audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization.

My signature below represents I have read and understand the terms and statements above.

This authorization form will remain in effect for 1 year from signature date unless revoked by me in writing, and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this authorization form is to be considered as valid as an original.

Patient Name (please print): _____ Date of Birth:___/___/_____

Patient Signature: _____ Date:___/___/ _____

Parent/Guardian's Signature: _____

Relationship to patient: _____

ACKNOWLEDGMENT OF PRIVACY PRACTICES RECEIPT

I **have been given** a brochure on Notice of Privacy Practices:

_____ _____
Patient or Guardian Signature Date

I **do not want** a brochure on Notice of Privacy Practices:

_____ _____
Patient or Guardian Signature Date