MISSISSIPPI PERINATAL

MATERNAL-FETAL MEDICINE

NEW PATIENT INFORMATION

Name: _____ DOB: _____ SSN: _____

Race/Ethnicity: _____ Marital Status: _____ Employer: _____ Email: _____

Address: _____ City: _____ State: _____ Zip code: _____

Cell: _____ Work: _____ Home: _____

INSURANCE INFORMATION

Primary Insurance: _____ Member ID: _____ Group ID: _____

Subscriber: _____ Subscriber DOB: _____ Subscriber SSN: _____

Secondary Insurance: _____ Member ID: _____ Group ID: _____

Subscriber: _____ Subscriber DOB: _____ Subscriber SSN: _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relation: _____

PHARMACY INFORMATION

Name: _____ Address: _____

Phone: _____

REFERRING PROVIDER

Name: _____

RELEASE OF PERSONAL INFORMATION

I hereby give my permission for Mississippi Perinatal, PLLC, doctors, and staff to disclose my personal medical information including billing, scheduling, lab results, clinic notes, imaging reports and medical treatment to the following individuals listed below:

Name	Relationship

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ACKNOWLEDGEMENTS AND CONSENTS

Acknowledgement of Notice of Privacy Practices

Initials _____ I acknowledge that I have received a copy of the Notice of Privacy Practices on the date indicated below. I understand that if any changes are made to this Notice of Privacy Practices, a revised coy of the Notice will be posted at Mississippi Perinatal, PLLC. I also understand that if I wish to receive additional copies of this Notice in the future or have any questions regarding the Notice of Privacy Practices, I may contact Mississippi Perinatal.

Release of Information

Initials _____ I, the patient, authorize Mississippi Perinatal, PLLC to release any medical information necessary for insurance processing and billing.

General Consent to Treatment/Test

Initials _____ I, the patient, am seeking medical treatment from Mississippi Perinatal, PLLC. I consent to examination from all medical staff including the physicians, nurses, sonographers and/or other health care professionals in this clinic. I consent to any medical procedures including laboratory tests, diagnostic testing, ultrasounds, amniocentesis and any other health care services ordered by the health care team. I understand that I can refuse any specific procedure or treatment by notifying my health care team.

Insurance Benefits and Acceptance of Financial Responsibility

Initials _____ I, the patient, authorize the use of my insurance for services rendered and authorize payment directly to Mississippi Perinatal, PLLC. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Mississippi Perinatal, PLLC to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

I understand that this consent is in effect until revoked by me by written notice to the practice.

_____ _____

Signature *Date*

_____ _____

Printed Name *Relationship to Patient (if not patient)*

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Cancellations and Missed Appointments

Our goal at Mississippi Perinatal is to provide the highest quality medical care possible. Late cancellations and "No Shows" create barriers for other individuals who need access to medical care in a timely manner. At Mississippi Perinatal, we recognize that certain life events can make it difficult to notify us in the event of needing to cancel or reschedule an appointment. If you must cancel your appointment, please follow the guidelines below:

Cancellation

We ask that you please be respectful of the needs of other patients and please notify our clinic when you are unable to attend a scheduled appointment. It is required that you notify the clinic no less than 24 hours in advance. A "late cancellation" occurs with failure to notify Mississippi Perinatal of cancellation less than 24 hours prior to your scheduled appointment time. Timely notification may allow another individual an opportunity to receive treatment.

Missed Appointment ("No Show")

A "no show" occurs if you fail to come to your scheduled appointment. "No shows" are recorded in the medical record. Each missed appointment or no show will be followed up by a clinic team member. Missed appointments or no-shows will result in a $50.00 fee for each occurrence.

How to Cancel Your Appointment

- Cancel or request rescheduling of an appointment in your MyChart portal.
- Call our clinic at (601) 973-7405 during normal business hours. If you do not reach a clinic representative, please leave a detailed voicemail including your telephone number. Someone will contact you to reschedule your appointment.

Due to the intricacies of our patient schedules, we do not allow patients to reschedule appointments electronically. You MUST CALL to reschedule an appointment.

I do hereby acknowledge that I have received and read the guidelines above and have had any portion of the guidelines that I do not understand explained to me.

Patient/Guardian signature _____ **Date**_____