Delaware Center for Maternal and Fetal Medicine of Christiana Care, Inc.

Important Information for Our Patients

Regular Office Hours

Our regular office hours are 7:00 am to 5:00 pm Monday through Friday. We are available by phone 7:30 am to 4:30 pm Monday through Friday.

Urgent Care After-Hours

Urgent care is defined as an issue that cannot wait until regular office hours. Calls received after hours or on days when the office is closed will be forwarded to our answering service for the physician on call. All urgent issues should be directed to your obstetrician. Please note that there is a $50.00 charge for patients paging the on call physician for non-medical issues.

Emergency Care

For a serious emergency call 9-1-1 immediately.

Patient Information and Identification

Patients are required to present a valid photo ID and current insurance card at each and every visit. Patients must promptly notify the practice in writing of any changes to their demographic and/or insurance information. Patients are also required to respond promptly to any requests for information from their insurance companies. Failure to comply with any of these provisions may result in a patient responsibility of our full fee for services rendered.

Appointment Confirmations

We will place a reminder call to your primary telephone number two business days prior to your scheduled appointment. At that time we will also leave information regarding any patient balances that would be due at check in at your upcoming appointment. We will leave a message on your voicemail if you do not answer.

Appointment Cancellations

If you need to cancel or reschedule your appointment we require notification at least one business day in advance. If you arrive more than 15 minutes late for your appointment you may need to be rescheduled. Failure to notify us in a timely manner may result in a $50 Missed Appointment Fee billed directly to you, not your insurance company. Missed appointment fees must be paid prior to any rescheduling of appointments. Multiple missed appointments may result in dismissal from the practice.

Photography and Videotaping

Recording devices are not permitted in the examination room. This includes, but is not limited to, the following: Digital cameras, video cameras, cell phone cameras, laptop cameras, etc. Images from your ultrasound will be provided to you at the end of your exam.

Fee Schedules

Our fee schedule has been calculated to include a reduction for Self-Pay Patients and CHAPS Program Members. A copy of our fee schedule is available upon request.

Insurance Companies (Participating)

We participate with some, but not all, insurance companies. A list of the companies with whom we participate is available upon request. If you are a member of an insurance company with whom we participate, we will submit claims directly to your plan on your behalf and accept their maximum allowable charge as payment in full. You are responsible for paying the appropriate deductible, coinsurance or copay amount as determined by your insurance company. This payment is due at the time of service prior to your appointment. Any additional patient responsibility identified by your insurance company on their explanation of benefits (EOB) will be due immediately.

Please note that a quotation of benefits by your insurance company may vary from the final determination of benefits during claims processing. Your insurance policy is a contract between you and your insurance company. If you have any questions about how benefits were determined you need to contact your insurance company directly.

Insurance Companies (Non-Participating)

If you are covered by a non-participating insurance company, payment in full will be required upon check in. A HCFA 1500 claim form will be mailed to you following your visit for you to submit to your insurance company for reimbursement.

Referral Authorization/Pre-Certification

Many insurance companies require referral authorization and/or pre-certification for specialty services. Please familiarize yourself with your insurance company's requirements. If the appropriate referral authorization has not been received in our office prior to your visit, your appointment may be rescheduled. If your insurance company denies a service for lack of referral it is your responsibility to pay the bill in full. It is important for you to remember to contact your PCP or Ob/Gyn before seeking services from a specialist.

Payment Options

Payment is due at the time services are rendered. Please come prepared to pay the appropriate amount due at each appointment. We accept cash, checks, money orders, MasterCard, Visa, and Discover.

Cash

We accept cash payments and will provide a printed receipt for all cash transactions.

Checks

We do not accept post-dated checks. You will be charged a $30 Returned Check Fee for any check returned to us for insufficient funds. Future payments must be cash, money order or credit card.

Credit Cards

We accept MasterCard, Visa, and Discover for patients who are interested in financing their healthcare expenses over time. Credit card payments may be made over the phone at 302-319-5680 ext 230 or on our website at www.dcmfm.com. You will be charged a $30 fee for each declined transaction.

Collections

Patient accounts which are past due will be referred to a collection agency. A 25% Phase 1 Collection Administration Fee will be added to the account at the time of referral. Accounts in collections beyond 90 days will be assessed an additional 25% Collection Administration Fee. Accounts referred to a collection agency may also be reported to the credit bureaus (Equifax, Experian, and TransUnion). This may affect your credit rating. Failure to pay your financial responsibilities after insurance may also be viewed as a breach of contract by your insurance company.

Dismissal from the Practice

Patients may be dismissed from the practice. Reasons for dismissal may include, but are not limited to: non-payment, excessive missed appointments, failure to follow agreed upon treatment plan or the refusal of a patient to maintain acceptable behavior.

Medical Record

All requests for copies of medical records must be submitted in writing. A medical records fee plus any outstanding patient balance must be received in our office prior to release of the record.

By my signature, I certify that I understand and agree to the above.

Patient Name (Printed): _____

DOB: _____

Patient Signature: _____

Date: _____

DCMFM Representative (Printed): _____