SADDLEBACK WOMEN'S HOSPITAL
SADDLEBACK MEMORIAL MEDICAL CENTER

24451 Health Center Drive • Laguna Hills, CA 92653
949-452-3546

Patient Financial Policies and Preadmission Form

Welcome to Saddleback Women's Hospital. You have chosen one of the most comprehensive birth centers in Southern California to have your baby. It is our goal to provide a warm, friendly place where your needs for comfort and caring will be met.

For your convenience, any necessary paperwork and insurance verification can be completed well in advance of the day of your delivery. Your preadmission packet includes the following material:

1. **Patient Guide.** Please read this important guide, which includes patients' rights, advanced directives, and other information you will need to know about your hospital stay.

2. **Preadmission Form.** Please read and complete the form. If you have a MemorialCare Card complete front of page 2. If not, complete back side of page 2.

3. **Conditions of Admission Form.** Please read and sign both forms (one for the mother and one for the baby) where indicated. Terms and conditions of the agreement evidenced by this form are not binding until you receive care and treatment from the hospital.

4. **Financial Agreement.** Please read and sign where indicated.

5. **Commitment to Safety.** Please read and sign where indicated.

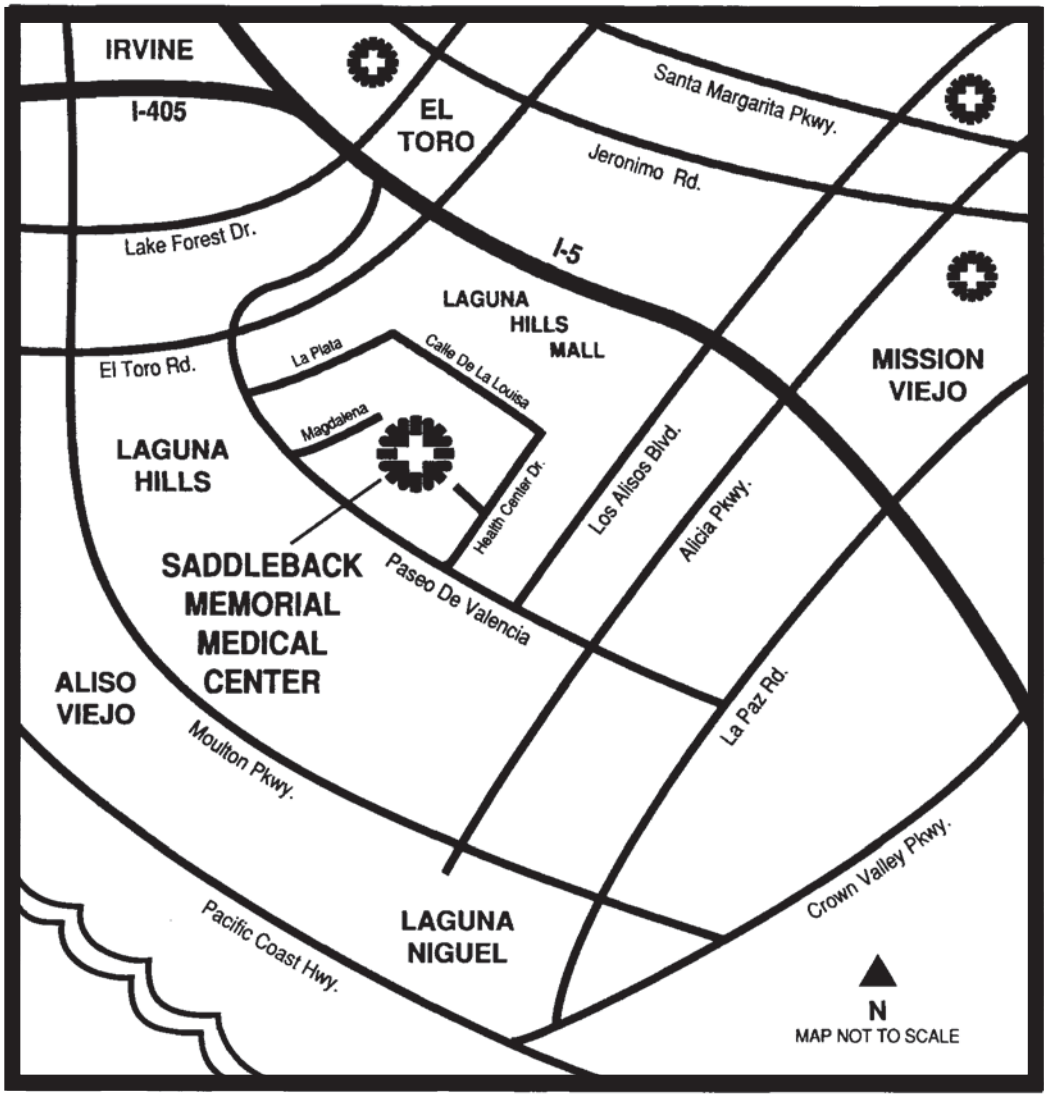
6. **Private Pay (No Insurance)** For cash customers – please contact our Patient Financial Advocate at 949/452-3576 for further information.

We have enclosed an envelope for you to mail the completed forms back to us. Be sure to include the completed Preadmission Form, the two signed Conditions of Admission Forms, Financial Agreement and front and back copies of your insurance cards.

Payment for services not covered by your insurance, including deductibles and estimated co-insurance payments, is due prior to or at time of discharge. You will be notified of the amount once your insurance coverage has been verified.

Check-in Location:	6 a.m. to 8 p.m., Saddleback Women's Hospital Front Entrance 8 p.m. to 6 a.m., Main Hospital Emergency Services Entrance
What to Bring:	You will need a few personal things such as toiletries, bathrobe, slippers, night clothes, infant clothes, receiving blanket, car seat, change for the vending machines, and your checkbook or credit card (Visa or Mastercard) to meet the prepayment requirements. For your safety, please leave all personal electrical items at home. These include hairdryer, curling irons, radios, etc.
Smoking:	Saddleback Memorial Medical Center is a non-smoking facility.
Check-out Time:	11 a.m. or earlier.
Visiting Hours:	General visiting hours are from 7 a.m. to 8 p.m., daily. Fathers have open visiting hours. Siblings and other immediate family can visit until 8 p.m., however they may not stay overnight. No other children (except for siblings) under the age of 16 are permitted.

If you have any questions concerning your admission, please contact Patient Access at (949) 452-3016, Monday through Friday, 8 a.m. to 5:30 p.m. We assure your birthing experience at Saddleback Women's Hospital will be comfortable and pleasant. Thank you for choosing Saddleback Memorial Medical Center, a MemorialCare facility.



SADDLEBACK WOMEN'S HOSPITAL

SADDLEBACK WOMEN'S HOSPITAL
SADDLEBACK MEMORIAL MEDICAL CENTER

Obstetrical Preadmission Information

PLEASE PRINT

24451 Health Center Drive • Laguna Hills, CA 92653
949-452-3546

EXPECTED DUE DATE _____ LAST MENSTRUAL PERIOD _____ DOCTOR NAME _____

PATIENT'S NAME (LAST, FIRST, MIDDLE) | AKA, ALSO KNOWN AS (LAST, FIRST, MIDDLE)

PATIENT'S ADDRESS | CITY | STATE | ZIP | AREA CODE | HOME PHONE

BIRTHDATE | AGE | MARITAL STATUS | SOCIAL SECURITY NO. | **MAIDEN NAME** | RELIGION

RACE: ☐ WHITE ☐ BLACK ☐ NATIVE AMERICAN ☐ ASIA/INDIA/PACIFIC ISLES | ETHNICITY: ☐ NON-HISPANIC ☐ HISPANIC

INDICATE IF YOU HAVE A DURABLE POWER OF ATTORNEY (RIGHTS TO MAKE DECISIONS ABOUT MEDICAL TREATMENT)

DATE COMPLETED: _____

EMPLOYER _____

EMPLOYER'S ADDRESS _____
CITY STATE ZIP

EMPLOYER'S PHONE ( ) _____ OCCUPATION _____

EMPLOYMENT ☐ FULL TIME ☐ PART TIME ☐ SELF EMPLOYED ☐ ACTIVE MILITARY ☐ NOT EMPLOYED ☐ FULL-TIME STUDENT

SPOUSE'S OR OTHER RESPONSIBLE PARTY INFORMATION

NAME _____ RELATIONSHIP _____

ADDRESS (if different from patient's) _____
CITY STATE ZIP

PHONE ( ) _____ SOCIAL SECURITY NUMBER _____

EMPLOYER _____

EMPLOYER'S ADDRESS _____

EMPLOYER'S PHONE ( ) _____ OCCUPATION _____

EMPLOYMENT ☐ FULL TIME ☐ PART TIME ☐ SELF EMPLOYED ☐ ACTIVE MILITARY ☐ NOT EMPLOYED ☐ FULL-TIME STUDENT

PRIMARY INSURANCE INFORMATION

INSURANCE NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE ( ) _____ POLICY # _____ GROUP # _____

SUBSCRIBER NAME _____ RELATIONSHIP _____ BIRTHDATE _____

SECONDARY INSURANCE INFORMATION

INSURANCE NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE ( ) _____ POLICY # _____ GROUP # _____

SUBSCRIBER NAME _____ RELATIONSHIP _____ BIRTHDATE _____

NEWBORN INSURANCE INFORMATION

☐ SAME AS PRIMARY INSURANCE LISTED ABOVE ☐ SAME AS SECONDARY INSURANCE LISTED ABOVE

☐ OTHER INSURANCE NAME: _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE ( ) _____ POLICY # _____ GROUP # _____

SUBSCRIBER NAME _____ RELATIONSHIP _____ BIRTHDATE _____

IN CASE OF EMERGENCY

GIVE NAME OF SPOUSE, PARENT, NEAREST RELATIVE OR FRIEND

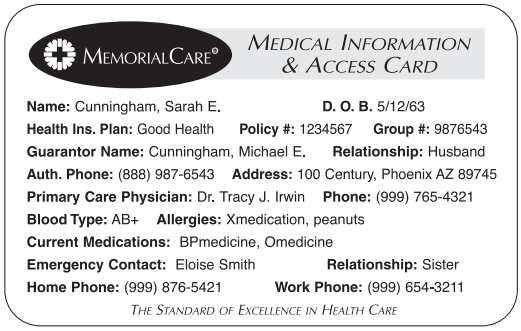
FULL NAME	RELATION	AREA CODE HOME PHONE	AREA CODE BUSINESS PHONE
ADDRESS	CITY	STATE	ZIP
FULL NAME	RELATION	AREA CODE HOME PHONE	AREA CODE BUSINESS PHONE
ADDRESS	CITY	STATE	ZIP

PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD

PATIENT'S DEDUCTIBLE AND ESTIMATED CO-INSURANCE IS DUE PRIOR TO ADMISSION OR AT TIME OF DISCHARGE. YOU WILL BE NOTIFIED OF THE AMOUNT ONCE YOUR INSURANCE COVERAGE HAS BEEN VERIFIED.

FOR CONVENIENCE, WE ACCEPT CASH, CHECKS, MASTERCARD AND VISA.

Complete This Side Only If You Have A MemorialCare Medical Information and Access Card . . .


MEMORIALCARE® MEDICAL INFORMATION & ACCESS CARD

Name: Cunningham, Sarah E. **D. O. B.** 5/12/63
Health Ins. Plan: Good Health **Policy #:** 1234567 **Group #:** 9876543
Guarantor Name: Cunningham, Michael E. **Relationship:** Husband
Auth. Phone: (888) 987-6543 **Address:** 100 Century, Phoenix AZ 89745
Primary Care Physician: Dr. Tracy J. Irwin **Phone:** (999) 765-4321
Blood Type: AB+ **Allergies:** Xmedication, peanuts
Current Medications: BPmedicine, Omedicine
Emergency Contact: Eloise Smith **Relationship:** Sister
Home Phone: (999) 876-5421 **Work Phone:** (999) 654-3211
THE STANDARD OF EXCELLENCE IN HEALTH CARE

PATIENT NAME _____ MEMORIALCARE CARD ID # _____

EXPECTED DUE DATE _____ SOCIAL SECURITY # _____ RELIGION _____

RACE: ☐ WHITE ☐ BLACK ☐ NATIVE AMERICAN ☐ ASIA/INDIAN/PACIFIC ISLES **ETHNICITY:** ☐ NON-HISPANIC ☐ HISPANIC

DURABLE POWER OF ATTORNEY (RIGHTS TO MAKE DECISIONS ABOUT MEDICAL TREATMENT) DATE COMPLETED _____

LAST MENSTRUAL PERIOD _____ OB DOCTOR _____

YOUR EMPLOYER NAME _____ OCCUPATION _____

ADDRESS _____
city state zip

EMPLOYMENT: ☐ FULL TIME ☐ PART TIME ☐ SELF-EMPLOYED ☐ ACTIVE MILITARY ☐ NOT EMPLOYED ☐ FULL TIME STUDENT

SPOUSE OR OTHER RESPONSIBLE PARTY INFORMATION – ONLY IF DIFFERENT FROM PATIENTS:

NAME _____ RELATIONSHIP _____

ADDRESS _____
city state zip

EMPLOYER _____ OCCUPATION _____

ADDRESS _____
city state zip

EMPLOYMENT: ☐ FULL TIME ☐ PART TIME ☐ SELF-EMPLOYED ☐ ACTIVE MILITARY ☐ NOT EMPLOYED ☐ FULL TIME STUDENT

NEWBORN INSURANCE INFORMATION:

☐ SAME AS PRIMARY INSURANCE LISTED FOR MOM ☐ SAME AS SECONDARY INSURANCE LISTED FOR MOM

☐ OTHER INSURANCE NAME _____

ADDRESS _____
city state zip

PHONE ( ) _____ POLICY # _____ GROUP # _____

SUBSCRIBER NAME _____ RELATIONSHIP _____ BIRTHDATE _____

SADDLEBACK WOMEN'S HOSPITAL
SADDLEBACK MEMORIAL MEDICAL CENTER

24451 Health Center Drive • Laguna Hills, CA 92653
949-452-3546

FINANCIAL AGREEMENT

Patient Name: _____

Date of Service: _____

Account Number: _____

Saddleback Memorial Medical Center (SMMC), a non-profit acute care facility, is dedicated to providing the very highest quality care and service to all of its patients.

The hospital will make every effort to ensure that you receive quality medical care which is medically necessary. However, please be aware that your health plan or designated medical group makes the final determination regarding your care.

SMMC will bill your insurance company for the healthcare services you receive at the hospital less any co-payment(s) or deductible(s). In the event that your insurance company denies payment for services as a result of, but not limited to, any reason or any reason listed below, you will be held financially responsible for the hospital charges incurred.

Payment may be denied if your health plan or medical group determines:

- **the care given is not medically necessary**
- **the care given is a non-covered benefit**
- **the care given is non-emergent**
- **the recipient is ineligible to receive the insurance benefit**
- **any additional hospital days and/or service requested are not a medical necessity and only for convenience**
- **the care was not authorized**

I understand insurance authorization has not been obtained, and I wish to have services rendered regardless. Initial here ( )

Out-of-Network Financial Agreement

I exercise my right to seek medical treatment without a referral from my Primary Care Physician/Medical Group. I understand that my Out-of-Network services have co-insurance charges, higher co-payments, and limited annual benefits. I also understand some Out-of-Network services such as hospitalization, outpatient surgeries, and cat-scans require pre-certification from my insurance company in order to receive full benefits. Initial here ( )

It is ultimately your responsibility to make sure that you obtain the necessary pre-authorization(s) from your health plan.

I have read the preceding information and my signature below serves as acknowledgment of a clear understanding of my financial responsibility. If my insurance company denies coverage and/or payment for services rendered to me at Saddleback Memorial Medical Center, I assume the financial responsibility.

Date	Time	Patient/Parent/Legal Representative
Witness		If signed by other than patient, indicate relationship