Obstetrical Medicaid Financial Agreement

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PATIENT NAME DATE OF BIRTH

I, the above listed patient of Stark Women's Center, acknowledge that I have been informed Stark Women's Center does not accept some Medicaid (and is not contracted with **Unison**, **Molina** and **Paramount**) as a primary and /or secondary insurance.

If I am a Medicaid enrollee in the above mentioned plans, I acknowledge that by signing this document, I am personally responsible for payment of all charges incurred during my pregnancy for my complete obstetrical care. I acknowledge that I choose not to use these above mentioned Medicaid plans as my primary and/or secondary insurance and will be considered a self-pay patient. In the future if I choose to utilize the above mentioned Medicaid plans, I agree to transfer to a Medicaid provider for my care.

_____ _____ _____

Patient Signature Date Witness Initials

Circumcision Medicaid Financial Agreement

I, the above listed patient of Stark Women's Center, acknowledge that I have been informed that if a circumcision is preformed I am personally responsible for the $275.00 circumcision fee.

_____ _____

Patient/Parent or Legal Guardian Signature Date

Melissa S. Vassas, DO Sunitha Jagadish, MD Carl T. Schleich, MD Randall Starcher, MD
Stephanie Weinberg, MD Jason Hoppe, DO Megan Staub, MD