



## OBSTETRICAL MEDICAID FINANCIAL AGREEMENT

\_\_\_\_\_  
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 Paramount, and Buckeye** ) 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  | Jason Hoppe, DO      | Megan Staub, MD      |