MemorialCare
Saddleback Medical Center

Patient Financial Policies
and
Preadmission Form

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

Welcome to The Women's Hospital at Saddleback. 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.

3. **Conditions of Admission Form.** Please read and sign 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. **Joint Notice of Privacy Practices.** Please read and sign Acknowledgement of Receipt.

5. **Private Pay (No Insurance)** For cash customers — please contact our Patient Financial Counselor at (949) 452-3177 for further information.

6. Please attach a copy of the front and back of your insurance card and photo ID.

We have enclosed an envelope for you to mail the completed forms back to us. Be sure to include the completed Preadmission Form, signed Conditions of Admission Form, Acknowledgement of Receipt 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. We accept Credit Cards, Cash, Money Order, or Check to satisfy the prepayment requirement.

Hospital Entrance: Saddleback Women's Hospital Front Entrance, proceed the 2nd Floor of Women's Hospital. Open 24 Hours a Day, 7 Days a Week.

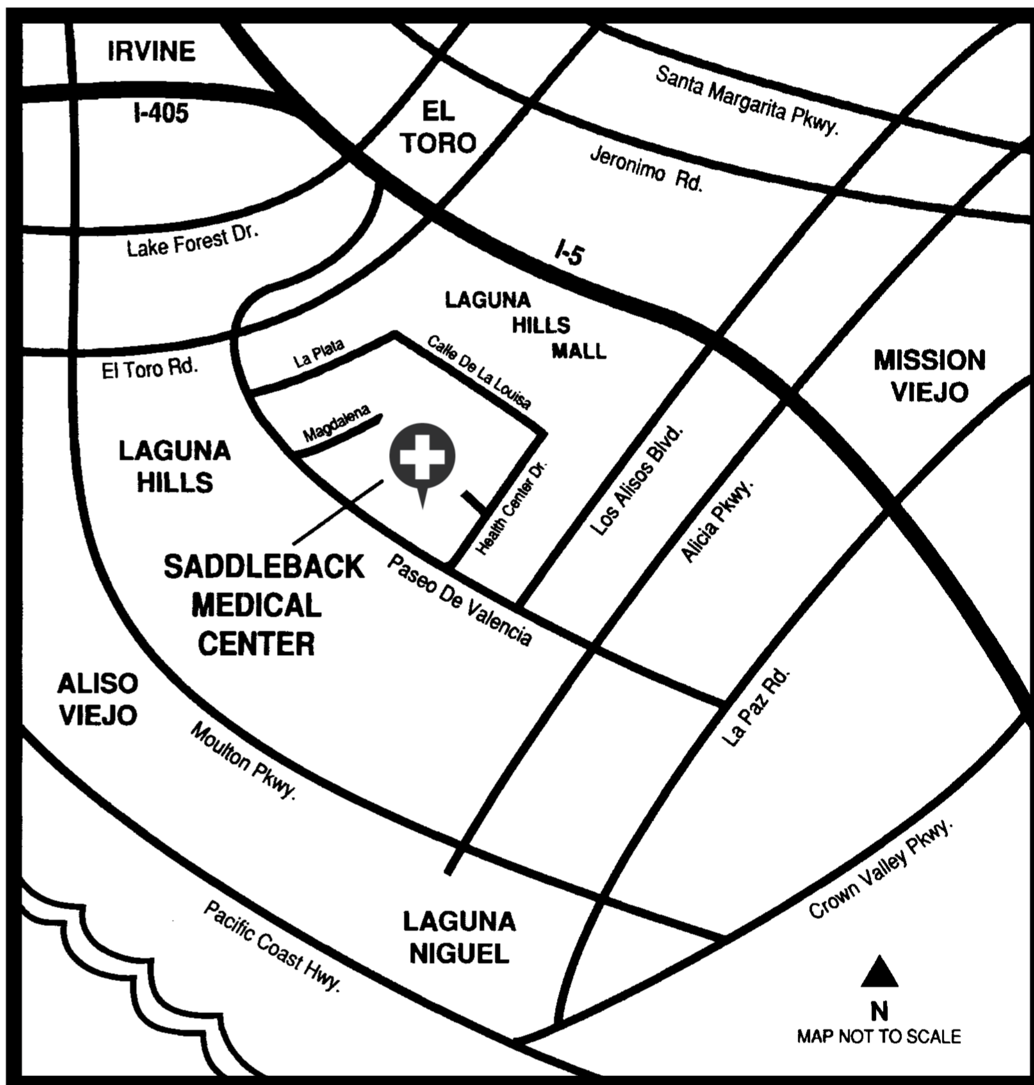
What to Bring: You will need a few personal things such as toiletries, bathrobe, slippers, night clothes, infant clothes, receiving blanket, car seat and change for the vending machines. For your safety, please leave all personal electrical items at home. These include hairdryer, curling irons, radios, etc.

Smoking: Saddleback Medical Center is a non-smoking facility.

Anticipated Discharge Time: 10 a.m.

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 Medical Center, a MemorialCare facility.


IRVINE
I-405
EL TORO
Santa Margarita Pkwy.
Jeronimo Rd.
Lake Forest Dr.
I-5
LAGUNA HILLS MALL
La Plata
Calle De La Louisa
El Toro Rd.
MISSION VIEJO
Magdalena
LAGUNA HILLS
Health Center Dr.
Los Alisos Blvd.
Alicia Pkwy.
SADDLEBACK MEDICAL CENTER
Paseo De Valencia
ALISO VIEJO
La Paz Rd.
Moulton Pkwy.
Crown Valley Pkwy.
Pacific Coast Hwy.
LAGUNA NIGUEL
N
MAP NOT TO SCALE

MemorialCare™
Saddleback Medical Center

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Saddleback Medical Center

Obstetrical Preadmission Information

PLEASE PRINT

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

PRIMARY CARE PHYSICIAN (PCP) NAME: ________________________________

Would you like us to notify your PCP when you are admitted? ❑ Yes ❑ No

Baby PCP ________________________

Your preferred pharmacy: ______________ Location: ________________________________

EXPECTED DUE DATE __________ LAST MENSTRUAL PERIOD __________ DOCTOR NAME ____________

MULTIPLE BIRTH: ❑ YES ❑ NO SURROGATE PREGNANCY: ❑ YES ❑ NO

PATIENT'S NAME (LAST, FIRST, MIDDLE)					AKA, ALSO KNOWN AS (LAST, FIRST, MIDDLE)	
PATIENT'S ADDRESS			CITY		STATE	ZIP
HOME PHONE ( )			CELL PHONE ( )		EMAIL ADDRESS	
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: ______________________________ PLEASE PROVIDE A COPY

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 ________

PROVIDER PHONE ( ) ________________ POLICY # ________________ GROUP # ________________

SUBSCRIBER NAME ________________________________ RELATIONSHIP TO PATIENT ________________

ADDRESS (if different from patient's) ________________________________

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

SECONDARY INSURANCE INFORMATION

INSURANCE NAME ________________________________

ADDRESS ________________ CITY ________________ STATE ________ ZIP ________

PROVIDER 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.