New Patient Demographics - Website Form

MOTHERHOOD TO MENOPAUSE MIDWIFERY CARE

Patient Demographic Information

Patient Name (Last, First, Middle) _____ **Nickname** _____

Birth Date _____ **Age** _____ **Sex** _____

Address _____ **City, State, ZIP** _____

Home Phone _____ **Cell Phone** _____

Email Address _____

Emergency Contact Name _____ **Emergency Contact Phone** _____

Marital Status _____ **Race** _____ **Ethnicity** _____

Preferred Language _____ **Employer** _____

Primary Care Physician (Name, Address, Phone Number) _____

How did you hear about us: *Select one*

☐ Patient Referral ☐ Provider referral:_____ ☐ Insurance referral ☐ Web search

☐ Social Media ☐ Event ☐ Direct Mail or Magazine ☐ Radio/TV ☐ Billboard ☐ Other:_____

Responsible Party Information (if different than above or if patient is a minor)

Guarantor Name (Last, First) _____ **Relationship** _____

Birth Date _____ **Sex** _____

Address _____ **City, State, ZIP** _____

Home Phone _____ **Cell Phone** _____

Email Address _____

Insurance Information

Primary Insurance	_____	**Secondary Insurance**	_____
Policy Holder Name	_____	**Policy Holder Name**	_____
Relationship to Patient	_____	**Relationship to Patient**	_____
Policy Holder DOB	_____	**Policy Holder DOB**	_____
Policy # / Member ID	_____	**Policy # / Member ID**	_____
Group #	_____	**Group #**	_____

PLEASE INCLUDE A CURRENT COPY OF YOUR INSURANCE CARD.

Patient / Guarantor Signature _____ **Date** _____

MOTHERHOOD TO MENOPAUSE
MIDWIFERY CARE

PATIENT CONSENT FORM & AUTHORIZATION TO BILL INSURANCE

Please read and initial by each item below, then sign at the bottom, please. Thank you.

_____ I certify that I am requesting the services of Motherhood to Menopause Midwifery Care for myself.

_____ I agree to advanced practice nursing students may be present as observers.

_____ I request payment of authorized insurance benefits or subsidies made, on my behalf, and payment made to Motherhood to Menopause Midwifery Care for any services provided to me. I authorize any holder to release to my insurance company my medical information that may be needed to determine benefits or the benefits payment for related services, regulatory compliance, status audit or quality assurance purposes.

_____ I understand that Motherhood to Menopause Midwifery Care will submit insurance claims and that I will be responsible for any deductibles, co-payments, co-insurance or client fees at the time services are rendered. I understand that there is 4% surcharge cost for using a credit card, Benefits card or similar.

_____I understand that I will receive a statement if my account has a balance due. I understand that Motherhood to Menopause Midwifery Care cannot accept responsibility for collection of my insurance claim or for negotiating a settlement on a disputed claim and that I am responsible for payment of my account.

_____ I understand that there is a 24-hour cancellation policy and if I fail to appear at the time of a scheduled appointment, I will be responsible for payment of that missed appointment.

_____ I understand that my services and/or treatment with Motherhood to Menopause Midwifery Care may be terminated in the case of non-compliance. This includes non-adherence regarding prescribed medications, and treatment plans; repeatedly missing appointments, or failure to pay the fees for services rendered and determined as obligatory by my insurance and the guidelines of the practice.

CLIENT'S PRINTED NAME_____**DOB**_____

CLIENT'S SIGNATURE_____**DATE SIGNED**_____

MOTHERHOOD TO MENOPAUSE
MIDWIFERY CARE

HIPAA PRIVACY PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e., my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA.

I understand that I have the right to request restrictions on how my protected health information is used and disclose to carry out treatment, payment, and health care operations, but that you are not required to agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoked this content is not affected.

CLIENT'S PRINTED NAME_____**DOB**_____

CLIENT'S SIGNATURE_____**DATE SIGNED**_____