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 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 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**______________

2021