MIAMI CERTIFIED NURSE MIDWIVES, LLC
TELEPHONE 305-898-0801
FAX 786-373-1885

MATERNITY CARE FINANCIAL AGREEMENT:

I, _____(PLEASE WRITE YOUR NAME HERE) HAVE CHOSEN TO RECEIVE CARE FROM MIAMI CERTIFIED NURSE MIDWIVES, LLC WHO CARES FOR LOW-RISK WOMEN THROUGHOUT THE PREGNANCY, HOMEBIRTH AND SIX WEEKS POSTPARTUM. THIRD PARTY PAYERS MAY COVER SOME OF THE COST OF MY CARE. I AGREE TO PAY FOR THE TOTAL OR REMAINING COST OF MY MATERNITY SERVICES. THE SERVICES PROVIDED BY MIAMI CERTIFIED NURSE MIDWIVES INCLUDES PRENATAL CARE VISITS, LABOR SUPPORT AND MANAGEMENT, VAGINAL DELIVERY WHEN POSSIBLE, REPAIR OF FIRST AND/OR SECOND-DEGREE LACERATIONS AND POSTPARTUM CARE. IF I CHOOSE TO LEAVE THE PRACTICE OR I AM TRANSFERRED PARTIAL REFUNDS ARE NOT GRANTED.

EXCLUDED FROM THIS AGREEMENT IS ALL CARE OUTSIDE OF OUTSIDE OF MIAMI CERTIFIED NURSE MIDWIVES, THIS COULD INCLUDE BUT IS NOT LIMITED TO ULTRASOUNDS, LABORATORY TESTING, MEDICAL DEVICES, TRANSPORT COSTS AND HOSPITAL COSTS, WHICH MAY INCLUDE FEES FROM PHYSICIANS, ANESTHESIA, OB/GYNS, NEONATOLOGY, NURSING SERVICES AND THE HOSPITAL FACILITY.

FINAL AND COMPLETE PAYMENT IS DUE BY *36 WEEKS OF PREGNANCY*. THE COST FOR MIDWIFE BASED MATERNITY CARE THROUGHOUT PREGNANCY HOME BIRTH AND UP TO 6 WEEKS POSTPARTUM IS $8,000.00

___ INITIAL VISIT $500 DUE AT TIME OF FIRST VISIT

___ I AGREE TO PAY $8,000.00.

___ I DO NOT HAVE HEALTH INSURANCE

___ I WOULD LIKE MY INSURANCE BILLED AS A COURTESY, IF/ WHEN MY INSURANCE REIMBURSES THE MIDWIFE WILL REFUND THE INSURANCE PAID AMOUNT TO THE CLIENT. I UNDERSTAND THE PAYMENT WILL BE LESS THAN THE CHARGES BY THE MIDWIFE.

___ IN TOTAL THERE WILL BE _____(# PAYMENTS)

Signature: _____ DATE: __/__/____

.