

MIAMI CERTIFIED NURSE MIDWIVES, LLC
MIDWIFE & Co.
9507 SW 160th St. #220
MIAMI, FL
TELEPHONE 305-517-6165
FAX 786-373-1885

MATERNITY CARE FINANCIAL AGREEMENT:

I, _____, (PRINT YOUR NAME) HAVE VOLUNTARILY CHOSEN TO RECEIVE CARE FROM MIAMI CERTIFIED NURSE MIDWIVES, LLC/ MIDWIFE & CO WHO CARES FOR LOW-RISK WOMEN THROUGHOUT THE PREGNANCY, HOME BIRTH AND SIX WEEKS POSTPARTUM. THIRD PARTY PAYERS MAY COVER SOME OF THE COST OF MY CARE. I AGREE TO PAY FOR THE TOTAL COST OF MY MATERNITY SERVICES. MY INSURANCE MAY REIMBURSE SOME PERCENTAGE OF THE COST OF MY CARE. THESE 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, I AM STILL RESPONSIBLE FOR THE COST OF MY CARE.

EXCLUDED FROM THIS AGREEMENT IS ALL CARE AND INCIDENTALS OUTSIDE OF MIAMI CERTIFIED NURSE MIDWIVES/ MIDWIFE & CO, THIS INCLUDES MEDICATIONS, CHILDBIRTH CLASSES, A BIRTH KIT OR EMERGENCY SUPPLIES, 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 **34 WEEKS OF PREGNANCY**. THE COST FOR CERTIFIED NURSE MIDWIFE BASED MATERNITY CARE THROUGHOUT PREGNANCY AND UP TO 6 WEEKS POSTPARTUM **\$8,000.00**

IN TOTAL THERE WILL BE _____ (choose a number 1, 2 or 3 payments) EACH AT A RATE OF
 1 PAYMENT @ \$8000.00 BY 34 WEEKS
 OR 2 PAYMENTS @\$4000.00 16 WEEKS/ 34 WEEKS
 OR 3 PAYMENTS @ \$2666.67 AT 16 WEEKS, \$2666.67 AT 28 WEEKS, \$2666.66 AT 34 WEEKS

I DO NOT HAVE INSURANCE OR MY INSURANCE DOES NOT COVER MY PREGNANCY OR BIRTH. I AGREE TO PAY FOR MY CARE.

MY INSURANCE MAY COVER A PERCENTAGE OF MY BIRTH ACCORDING TO THE OUTSIDE BENEFITS VERIFICATION SERVICE. WWW.DOYLEBILLING.COM I AGREE TO **PAY FOR CARE AND AWAIT REIMBURSEMENT**. IF I LOSE OR CHANGE MY INSURANCE, I MUST RECHECK BENEFITS AND I AM RESPONSIBLE FOR THE ENTIRE COST OF CARE.

HYBRID PLAN, I WILL ONLY HAVE PRENATAL CARE, FOR DELIVERY I WILL GO ELSEWHERE, MY FIRST VISIT IS \$500.00, THEN \$3500.00 IS DUE FOR THE REST OF MY CARE.

OTHER PLAN _____

Signature: _____ DATE: __/__/____