SOUTHWEST MIDWIVES PATIENT INFORMATION
PLEASE PRINT & FILL OUT COMPLETELY

Today's Date: _____

Patient Name: _____
Last Name First Name Middle Name

Address—Physical: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Employer: (____) _____ Work Phone: (____) _____

May we leave a message at home/cell/work? Yes No Email: _____

Date of Birth: _____ Social Security #: _____ Marital Status: M S W D

Emergency Contact: _____ Relationship to patient: _____

Home/cell Work Phone: _____

Primary Care Physician: _____ Who told you about us: _____

Preferred Pharmacy: _____ Pharmacy City: _____

Race (circle one): American Indian/ Alaska Native Hawaiian/ Pacific Islander Asian
African American White Decline Unknown

Ethnicity (circle one): Hispanic/Latino Not Hispanic/Latino Unknown Decline

Who is responsible for this account? (*Fill out if different from above)* _____

SSN: _____ DOB: _____ Relationship to patient: _____

Mailing Address: _____ City: _____ State: _____

Zip: _____ Home/Cell Work phone: _____

Check all that apply:

☐ Authorization to Consult with Four Corners OB-GYN: I hereby authorize Southwest Midwives to release my medical information to four Corners OB-GYN on the event my care requires a physician consultation.

☐ Third Party Payor Authorization/ Release: I hereby authorize direct payment to Southwest Midwives of any third party payor benefits (insurance company, government agency, ect.) I hereby authorized Southwest Midwives to release medical records to any third party payor.

☐ Authorization for PBM (Prescription Benefit Manager): I hereby authorize Southwest Midwives to have access to all PBM information.

Signature (patient or Guardian)

_____

INSURANCE INFORMATION (We need a copy of your most *current* card):

Insurance company: _____

Member ID #: _____ Group ID#: _____

Claims Address: _____ City: _____ State: _____

Zip: _____ Customer Service Phone #: (____) _____

** Please be sure to let us know if any of your information changes so we can keep our records current. Thank you!**

PATIENT INFORMED CONSENT

Please make sure YOU are informed of your insurance benefits

*****Please initial each line upon reading.*****

Today's Date: _____

1. _____ **NOTICE TO OUR PATIENTS REGARDING PAYMENT**:

- *If you are **SELF PAY**—*FULL payment of services rendered is required at the time of service.
- **CURRENT INSURANCE CARDS MUST BE PRESENTED AT THE TIME OF SERVICE**
- *If we **ARE** contracted with your insurance*—FULL payment of co-pay's, co-insurance, or deductibles are required at the time of service. We will bill your insurance—*as a courtesy to you*. Please understand if we are not contacted by your insurance *within 60 days* the balance will be your responsibility.
- *If we **ARE NOT** contracted with your insurance*—FULL payment of services is required at the time of your visit. We will bill your insurance—*as a courtesy to you*, but full payment is required at the time of service, if a refund is due to you we will issue it when insurance pays us. Please understand if we are not contacted by your insurance within 60 days, the balance will be your responsibility. Or we would be happy to give you the necessary paperwork so you can bill your insurance yourself.
- ***OB patients***: We will bill your insurance, whether we are contracted or not, for your global package— *as a courtesy to you*. The above information *does apply* to services not covered in your OB contract. Please be familiar with what this includes. Non-global problem visits are billed separately.

2. _____ **OB patients with Blue Cross Blue Shield:** For the most part this insurance ONLY pays for ONE ultrasound /pregnancy. If you chose to have a pregnancy confirmation ultrasound as well as the routine 20-week ultrasound, be aware that you may be responsible for full payment of the 20-week ultrasound.

3. _____ **Pre-authorization Requirements:** Southwest Midwives will obtain *ALL referrals from other physicians,* or *pre-authorizations from insurance* to be in compliance with your insurance or medical coverage. However, it is very helpful to us if you are also aware of your insurance requirements and double-check with us that we are meeting those requirements. *If SWMW fails to obtain a required pre-authorization, we will do our best to correct the mistake, but ultimately, you will be responsible for payment.*

4. _____ **Annual Exams:** Some insurance companies do not cover preventive care visits. Due to insurance fraud issues, we *cannot* change the reason for your visit *AFTER* you have left the office. We contract with many insurance carriers to offer you discounted services and specialty care, but we do not know what your specific plan covers. Please let us know whether you are being seen for a problem or a routine physical exam, so that we may provide you with appropriate care and avoid insurance disappointments.

5. _____ **Record Release:** We do charge a fee to release records, unless one of our doctors has referred you elsewhere. We **only** release records for visits and tests done here at this office.

6. _____ **All Medicaid patients** are responsible for ensuring they are eligible for Medicaid benefits at the time of service. *Proof of this eligibility is required in the form of a Medicaid card, an eligibility letter from Medicaid, or an eligibility letter from your case worker.* If Medicaid denies a claim due to *ineligibility* 100% payment is the patient's responsibility.

7. _____ **Account Balances:** All past due balances, or collection accounts must be *paid in full at the time you come in* for your appointment. You may call to set up payment arrangements, but these must be reasonable and paid in a timely manner. All arrangements MUST be made in advance!

8. _____ **Cancellations**: In order to provide the best possible service and availability to ALL our patients, should you need to cancel your appointment, we ask that you please do so at least 24-hours in advance. *If your appointment is **not** cancelled in advance a fee of $30 will be assessed to your account.*

9. _____ **Emergency Contact:** I give my consent to both SW Midwives and Aspen Billing to discuss finances and medical information with my listed Emergency Contact.

Signature (Patient/Guardian):_____Patient D.O.B: _____/_____/_____

Contract of Financial Responsibility

In agreeing to be responsible for your medical care, Southwest Midwives requires that you be responsible for your financial obligations to us.

Please read and initial each paragraph and sign where indicated to acknowledge your understanding and acceptance. If you are a minor (under 18 years of age), your parent or legal guardian must accept financial responsibility on your behalf.

1. _____ I agree that I will pay in full for all services provided to me by Southwest Midwives *at the time of service*, unless my services are covered by a contracted insurance.

2. _____ I understand that my insurance company or health plan may require me to pay co-payments, co-insurance or deductibles. I agree to pay these in full *at the time of service, or within* ***30 days*** *if billed separately.*

3. _____ I understand that if my contracted insurance has not paid within 60 days of billing them, **I will be required to contact them to find out why the claim has not been paid**. I understand payment is my responsibility at that time as well.

4. _____ I understand that if, 60 days after billing, I fail to pay any balance due on my account, further action may be taken on my account, unless other previous arrangements have been made and approved by Southwest Midwives.

5. _____ **If my account is sent to collections, or I am taken to small claims court, I am responsible for all amounts due *plus* all collection and court costs including**:
   - A handling charge—up to 50% of my account balance, or an interest fee of 33% from the date of service—will be added to my account.
   - If I am taken to small claims court an extra handling charge of $210.00 will also be added to my account.
   - All collection expenses charged by the collection agency, or court costs incurred.
   - All reasonable attorneys' fees.
   - Any discounts I may have received on my account will be reversed.
6. _____ I also understand that at the discretion of Southwest Midwives, I may be taken to small claims court for full reimbursement of all fees and balances.
7. _____ If further action must be taken on my account, Southwest Midwives may require me to permanently seek further care elsewhere, in accordance with guidelines set forth by the Colorado State Board of Medical Examiners.

Thank you very much.

Signature (Patient or Guardian):_____D.O.B: _____

Please print name:_____Today's date: _____

Provider Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Use and Disclosures of Health Information:

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, to evaluate the quality of care that you receive, and in consultation with the physicians at Four Corner's OB/GYN when protocols require a chart review. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax or other methods.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask you for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop further uses and disclosures.

We may change our policy at any time. Before we make a significant change in our policy, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person(s) listed in the "*Our Legal Duty*" section below.

Individual Rights:

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you only normal photocopy fees. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes and other than when you explicitly authorized it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add missing information.

Complaints:

If you are concerned that we violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person(s) listed in the "*Our Legal Duty*" section below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person(s) listed in the "*Our Legal Duty*" section below can provide you with the appropriate address upon request.

Our Legal Duty:

We are required by law to protect the privacy of your information, provide this notice about our information practices that are described in the notice, and obtain your acknowledgment of receipt of this notice. If you have any questions or complaints, please contact Mary-Louise Walton, CNM or Amy E. Ginn, CNM, (co-owners of Southwest Midwives Inc.) at the address listed above.

Acknowledgement of Receipt of Notice of Privacy Practices

Please sign your name and print your name and date on this acknowledgement form and return to the receptionist or to the address above. (Upon request, we will gladly provide you with a copy of this privacy notice for your records.)

Signature: _____

Printed Name: _____

Date: _____