NAME: _____ **DATE:** _____

List Reasons for Today's Visit:

1-_____

2- _____

3- _____

Date of Last-

Pap: _____ Mammo: _____ Dexa: _____ Colonoscopy: _____

SOCIAL HISTORY

First Day of Last Period: _____ Birth Control: _____

Current Medications: _____

Allergies: _____

Cigarettes Per Day: _____ Alcohol Use: _____ Drug Use: _____

Exercise Routine: _____ Daily Supplements: _____

SEXUAL HISTORY

Length of Time With Current Partner: _____

Total Partners in Past 12 Months: _____ Total in Lifetime: _____

Sexual Preference: M _____ F _____ Both _____

History of Sexually Transmitted Infections: _____

History of Abnormal Pap Smears: _____

Abnormal Colposcopy: _____ LEEP: _____ Cryo/conization: _____

OBSTETRIC HISTORY

Pregnancies: _____ # Live Children: _____

Abortions: _____ # Miscarriages: _____

ETHNICITY/NATIONALITY(circle)		GEOGRAPHICAL(circle)	
Native American	South Asian	United Kingdom	India
Mediterranean	Hispanic	Appalachian	China
Middle Eastern	Not Hispanic	Egypt	Mexico
Pennsylvania Amish	Africa	Other:_____	
French Canadian	Cajun-Louisiana		
Indian	West Indian		
Ashkenazi Jewish	Other:_____		

TURN PAGE OVER

MIDWIFERY CARE, INC.

PATIENT INFORMATION FORM

Name (first middle last):_____
Birth date: _____ Marital status: _____ SSN:_____
Address: _____ City: _____ State: _____ Zip: _____
License Number:_____
Home #:_____ Cell #: _____
Employed? _____ Employer phone: _____ Occupation:_____
Employer name:_____ Employer Address:_____
Primary contact: (circle) : home/ cell/ work
Is it ok to leave message on voicemail? ____ (initial)
Is it ok to receive appointment reminders via text message? _____ (initial)
Race: _____ Religion: _____
Ethnicity: _____
Email: _____
Preferred Pharmacy (Name, Street, City):

Emergency contact: _____ Phone: _____
Relation: _____
Spouse/Parent: _____ Phone: _____
Relation: _____

Consent to request medical history? (Signature)_____
Family Doctor (First and Last name and phone #)_____

INSURANCE INFORMATION

(Please give I.D. & insurance cards to receptionist to copy)

Primary Insurance: _____
ID#_____ Group #_____

Name of Insured: _____ DOB_____ SSN_____

Secondary Insurance: _____
ID#_____ Group#_____

Name of Insured: _____ DOB_____ SSN_____

I understand and agree that regardless of my insurance status, I am responsible for the balance of my account for any professional services rendered. I have read all the above information and have answered honestly to the above. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in regards to any of the above information. Any incorrect insurance information will result in my full responsibility of my bill.

_____ _____ _____
[redacted] (of Parent/Legal Guardian if Minor) Date Parents DOB (if Minor)

_____ _____
Witness Date

MIDWIFERY CARE, INC.

BILLING POLICY and FINANCIAL CONTRACT

Midwifery Care, Inc. provides gynecological and obstetrical services as well as diagnostic ultrasound exams. We would like to take a moment to briefly explain our office financial policy in relation to our policy for billing and collecting from your insurance company/companies and your responsibility for any remaining balance that is owed for the services provided.

We will gladly bill your insurance company as a courtesy to you. However, should your insurance company refuse payment, deny services, or need additional information from you, the patient, which is not submitted, the outstanding balance will be submitted to you for payment and is your responsibility to follow-up with your insurance company for possible payment.

We do accept Medicare assignment. This means that we accept the amount Medicare has allowed for your procedure, not necessarily the amount that Medicare pays. Medicare pays 80% of their allowed amount, (minus any yearly deductible) leaving a 20% remaining balance. We will automatically submit the remaining balance to any secondary insurance you may provide to us. After all insurance has been billed if there is a remaining balance, a statement of all transactions will be mailed to you specifying the amount that is owed by you.

We are credentialed or participate with several insurance companies' plans. It is virtually impossible for us to know if we participate as a provider with your insurance company due to the constant changes with insurance contracts. Therefore, it is your responsibility to know whether we are a listed provider with your insurance company. For more information, you should contact Tiffany in our billing department at 330-629-9991. Similar to Medicare assignment, if we are contracted with your insurance company, we accept what the insurance companies allow, not necessarily what they pay. The same billing procedure will be followed for all insurance companies in relation to secondary insurance's and patient responsibilities as stated above with Medicare Assignment. If we are not contracted with your insurance company, any unpaid balance due to an out of network service will be sent to you for payment. If you do not have any insurance coverage and your exam will be paid solely by you, we will need **payment in full on the day services are rendered**.

You will receive a statement for the remaining balance that you owe in a timely manner. Payment can be paid by cash, check, credit card or money order. After thirty days, there will be a $5 charge for any monthly statements sent thereafter. Any remaining balance **after ninety days** you will receive a notification in regards to your account and if we do not get a response from you within ten days of this notice you will be sent to **our collection agency** and your balance will go on your credit report.

PRENATAL PATIENTS: This contract is for global services rendered by Tammy M. Daugherty, MSN, CNM. These services include: routine prenatal care visits, labor and vaginal delivery, and postpartum care, the total cost is $2,900.00. You will be responsible for any remaining balance that your insurance company has noted as your responsibility prior to your delivery. In this contract, you agree to pay monthly beginning at the initial OB visit, and then every month until your bill is paid in full. The formula for monthly amount due is your total responsibility divided by the number of months until you are due. Your final payment is due by the first day of the month in which you are due. All **self pay** patients need to pay this charge in full by the first day of the month in which you are due. Please see Tiffany regarding your individual payment plan arrangements.

The cost above DOES NOT include any laboratory, ultrasounds, other special testing or problem visits not related to pregnancy. Furthermore, if you develop any complications, this may increase your charges and will need paid for at time of service.

GYNECOLOGICAL PATIENTS: The patient agrees to pay a minimum of $200 or insurance copayment on the day services are rendered and then each month pay any remaining balance in full. The patient also agrees to pay for any outstanding balance not covered by insurance company, prior to next appointment.

_____ (of Parent/Legal Guardian if Minor) _____ Date

_____ Witness _____ Date

MEDICAL HISTORY

____ Breast Mass
____ Headaches
____ Migraines
____ Dizzy Spells
____ Passing Out
____ Visual Changes (Glaucoma, Cataracts)
____ Thyroid Disease
____ Goiter
____ Weight Loss/Gain
____ Asthma
____ Respiratory Disease
____ Emphysema/COPD
____ TB
____ Heart Disease
____ Mitral Valve Prolapse
____ Heart Attack

____ Stroke
____ High Blood Pressure
____ High Blood Pressure (During Pregnancy)
____ High Cholesterol

____ Gallbladder Disease
____ Liver Disease
____ Cirrhosis

____ Abuse (Physical, Verbal, Sexual)
____ Alcohol/Drug use

____ Irregular Periods
____ Heartburn/ Ulcers
____ Anorexia
____ Bulimia
____ Nausea/Vomiting
____ Constipation/ IBS
____ Diarrhea
____ Bladder/Kidney Infection

____ Skin Disease (Eczema, Psoriasis, Skin Cancer)
Where:_____
____ Cancer
____ Diabetes
____ Diabetes (during pregnancy)
____ Anemia
____ Blood Disorder (Factor V, Sickle Cell, Thrombocytopenia, Thalassemia, Thrombophillia, MTHFR)
____ Phlebitis/Blood Clots (Lung/ Leg)
____ Blood Transfusion
____ Epilepsy/Seizures
____ Emotional Condition (Depression, Bipolar, Schizophrenia, Anxiety)

____ Mono
____ Hepatitis
____ Sexually Transmitted Infections

____ HIV
____ Other

SURGICAL HISTORY

____ Tonsil/Adenoids
____ Breast Reduction
____ Breast Implants
____ Gall Bladder
____ Bariatric Surgery/Gastric Bypass
____ Hysterectomy
____ Ovaries Removed
____ C-Section

____ Ablation
____ Abortion
____ Tubal Ligation
____ Essure
____ Appendix
____ Colonoscopy
____ D & C
____ Other: _____

FAMILY HISTORY

____ Heart Disease
____ Stroke
____ Diabetes
____ Thyroid Disease
____ Liver Disease
____ Alcohol/Drug Abuse

____ Physical/Sexual Abuse

____ High Blood Pressure
____ Cancer (Breast, Colon, Stomach, Bone, Pancreas, Skin)
____ Respiratory Problems(asthma/emphysema/TB)
____ Kidney Disease
____ Mental Illness(Depression, Bipolar, Schizophrenia, Anxiety)
____ Blood Disorder (Factor V, Sickle Cell, Thrombocytopenia, Thalassemia, Thrombophillia, MTHFR)
____ Other: _____

MIDWIFERY CARE, INC.

OFFICE POLICIES

ASSIGNMENT OF BENEFITS

I give my consent to treatment by Tammy M. Daugherty, MSN, CNM .
I hereby authorize *Midwifery Care, Inc.* to file insurance claims for services rendered on my behalf.

I hereby authorize payment directly to *Midwifery Care, Inc.* for any medical/surgical benefits, if any, otherwise payable to me for their services by my primary insurance carrier and secondary insurance carrier when applicable. I also understand that I am financially responsible for all charges not covered by assignment of benefits including any deductible and co-insurance as per my contract with my insurance carrier.

By signing below I have also read the HIPPA guidelines for Midwifery Care, Inc. You may request a copy to be given to you by simply asking the Office Coordinator.

OFFICE FEES & MISC. POLICIES

These fees are billed directly to you, the patient, and are not billed to the insurance company.

- We require a 24-hour notice of cancellation if you cannot keep your appointment. This allows us adequate time to fill your appointment time with another patient. If you do not notify us within 24 hours or you do not show up for a scheduled appointment, you will be charged a missed appointment fee of **$50** that will be billed directly to you and not your insurance company.

- Reminders calls/texts are a COURTESY, it is your responsibility to keep/reschedule appointments. After reminder text/call if we do not have appointment confirmation it is our right to give your appointment time to another patient.

- A fee of **$50** will be assessed on any non-sufficient fund check and will be due immediately upon notification from the office.

- A fee of **$40** will be assessed to transfer copies of Medical Records to a new provider for you or if we provide the copies to you directly. This fee along with any outstanding balance due us from services rendered to you must be paid in full prior to release of said records.

- A fee of **$25** will be charged for prescriptions sent in that are not related to a current appointment. At no point in time will a prescription be phoned in, they are all sent electronically.
  ***For example – failure to pick up prescription, loss of prescription, failure to reschedule return appointment in appropriate amount of time, change of pharmacy, etc.**

- A fee of **$10** for non-payment of copay at time of visit will be assessed to you.

- If you are non-compliant with medical care and require certified mail, we will charge you a **$15** fee for processing.

- A fee of **$20** for completion of forms (i.e.: disability, leave of absence, employee physicals, etc.).

- If you are more than 15 minutes late for your appointment, you may be asked to reschedule.

RIGHT TO PRIVACY DECLARATION

Every patient of *Midwifery Care, Inc.* has a basic legal right to privacy of her medical records and no patient's right to privacy may be abridged without her free will and informed consent. No information released to your plan shall be released to any other party without written consent of *Midwifery Care, Inc.* No information regarding HIV, mental health, drug/alcohol addiction or other conditions mentioned in the Americans with Disabilities Act will be released unless the patient has given *Midwifery Care, Inc.* specific written permission to do so.

[redacted] (of Parent/Legal Guardian if Minor) _____ Date _____

Witness _____ Date _____