MIDWIFERY & WOMEN'S HEALTH CARE

Laura Gore, CDM, CPM
Trina Strang, CNM, ANP
Felicity Smith, CDM, CPM
Patricia Young, CNM, WHNP, ANP
Tapia Stover, CNM, ANP

Patient Intake Form

Name _____ Sex _____ DOB _____

Mailing Address _____

Physical Address _____

Home Phone _____ May we leave a detailed medical message? Y / N

Work Phone _____ May we leave a detailed medical message? Y / N

Cell Phone _____ May we leave a detailed medical message? Y / N

Email Address _____ SSN _____

Spouse/Partner Name _____ DOB _____ Phone # _____

How did you hear about us? Radio Instagram Facebook Magazine Friend Other

If friend or other, who can we thank? _____

Primary Insurance Name _____

Name of Insured/Policy Holder _____ DOB _____

ID# _____ Group# _____ Relationship to Insured _____

Secondary Insurance Name _____

Name of Insured/Policy Holder _____ DOB _____

ID# _____ Group# _____ Relationship to Insured _____

Employer Information (name and phone number):

Self: _____ Partner: _____

Emergency Contact Person: _____ Phone # _____

Relationship _____

Authorization to Release Information and Assignment of Benefits: I give consent, by signing below, to Midwifery and Women's Health Care (MWHC) to release the above personal data as well as all or part of my medical records as required in the course of examinations and treatment for purposes of billing and filing insurance claims/payer coverage, related to the care provided. I consent to assign all payments for services to MWHC or persons billing on their behalf, for care performed or services rendered by Trina Strang, CNM, Patricia Young, CNM, Laura Gore, CDM, Felicity Smith, CDM, Tapia Stover, CNM or any other providers or consultant staff to the patient named above.

Please turn over and complete the other side. Thank you!

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Release of Protected Health Information: I authorize, by signing below, MWHC to release my Protected Health Information (PHI), which includes appointment time/information, billing questions/concerns and individually identifiable health information, to:

Name: _____ DOB _____ Relationship to Patient _____

Name: _____ DOB _____ Relationship to Patient _____

Name: _____ DOB _____ Relationship to Patient _____

Assumption of Financial Responsibility: I, by signing below, assume financial responsibility for payment of fees stemming from care rendered or services provided by MWHC to the patient named above. Insurance or other coverage may pay for part of these changes, and I assume responsibility for any unpaid portion. In the event that insurance does not cover charges within 60 days, I understand that the balance will now be my responsibility. Furthermore, I understand that if I fail to pay outstanding balances or fail to comply with an arranged payment plan, I will be turned over to Cornerstone Collection Services and.

HIPAA Notice of Privacy Practices: I have reviewed MWHC's HIPAA Notice of Privacy Practices (we will provide you with a copy for your records upon request).

Clients Rights and Responsibilities: I have reviewed and agree to MWHC's Rights and Responsibilities (a copy is provided upon request).

Informed Disclosure for Midwifery Care: I have reviewed and was able to have any questions answered regarding MWHC's Informed Disclosure for Midwifery Care (we will provide you with a copy for your records upon request).

Consent for Care: I, by signing below, authorize MWHC, and any employee working under the direction of the midwives, to provide medical care for me, or to this patient for whom I am the legal guardian. This medical care includes, but is not limited to, services and supplies related to my (or the identified persons) health, preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body, the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

- I certify by signing below that the information above is, to the best of my knowledge, accurate.

Signature of Patient/Responsible Party _____ Date _____

Patient Name (if different than responsible party) _____

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