Welcome to Seasons Midwifery & Birth Center! We understand you have many options for healthcare providers. We are happy that you chose us! We are here for you and hope to make your visit as pleasant as possible.

In order to get to know you better and eliminate some of your waiting time, we are enclosing your new client paperwork in this packet. ***Please complete all the forms and bring them with you to your appointment.***

Please have your current insurance card and a photo I.D. with you (a driver's license or state-issued identification card will be sufficient). The enclosed checklist should help you remember everything for your appointment.

It is our policy to collect all co-payments, co-insurance, and deductibles at the time of service. If you are unable to make such payments at the time of your appointment, please call our billing department at 303-280-2229, option 3 to make financial arrangements prior to your visit. We now offer Simple Solutions, an easy way to make automatic payments on your account through your credit card. You will find the paperwork for Simple Solutions enrollment in this packet.

Our providers make every effort to maintain a time-efficient schedule however; occasionally a client will have more questions than expected and will require extra time. We will do everything we can to accommodate your schedule. Please understand this is a people-business and schedule changes and interruptions are sometimes unavoidable.

The patient portal, accessed through our website, seasonsbirthcenter.com, has options to request an appointment, request prescription refills and pay your bill. Our website also offers educational material, pictures and biographies of our staff, as well as many useful links. You can also find us on Facebook at www.facebook.com/seasonsbirthcenter. You can also stay informed about classes and center news through our Facebook page.

If you ever have a concern, a question, or a compliment, please feel free to contact our office. You can call us at our main phone number, 303999-3950 or send an email to: info@seasonsbirthcenter.com. Our Patient Experience Coordinator will research your request and respond to you promptly.

Thank you for choosing Seasons Midwifery & Birth Center! We look forward to seeing you soon!

Sincerely,

The staff at Seasons Midwifery & Birth Center

PATIENT INFORMATION

Legal Name____

Last first Middle Initial

Street Address____ Apt/Unit #_________________

City_______________________________________ State____________ Zip Code_________________

Birth Date__________ Age____ SS #_____________________ Marital Status / / S / / M / / D / / Other

Race ___________________________ Ethnicity - Hispanic // Non-Hispanic // Decline

Home Phone________________________________ Work Phone________________________________

Mobile Phone_______________________________ Email Address ______________________________

Preferred Pharmacy___________________________ Address____________________________________

Spouse/Responsible Party: Name____________________________ SS#_________________________

Work Phone____________________ Employer/Occupation_________________________________

INSURANCE INFORMATION

Primary Insurance____ Type (HMO, PPO, etc)__________

Insured's Name__________________________________ Relationship to Insured_____________________

ID #_________________________ Group #__________________Insured's Birth Date__________________

Claims Address____

Membership Services Phone_____________________________________ Effective Date_______________

Secondary Insurance____ Type (HMO, PPO, etc)__________

Insured's Name__________________________________ Relationship to Insured_____________________

ID #_________________________ Group #___________________Insured's Birth Date_________________

Claims Address____

Membership Services Phone_____________________________________ Effective Date_______________

ADDITIONAL INFORMATION

Emergency Contact______________________________ Relationship to patient_______________________

Home Phone__________________________________ Work phone_________________________________

Family Physician_______________________________ Phone number_____________________________

Whom may we thank for referring you? ____

==

MEDICAL INFORMATION AUTHORIZATION: I authorize release of any medical information necessary to process my claims.

Signed____Date____________________________

ASSIGNMENT OF BENEFITS AND AGREEMENT FOR PAYMENT: I authorize medical benefits to the named provider. I understand that I am financially responsible for charges not covered by this authorization. I agree to pay all noncovered fees incurred within 30 days or my account may incur interest at the rate of 18% ANNUAL PERCENTAGE RATE. I further agree to pay all costs including actual attorney fees incurred for collection of my account.

Signed____ Date_________________________________

NAME____ DATE_______________

PLEASE NOTE ANY SYMPTOMS YOU HAVE RECENTLY HAD THAT YOU FEEL ARE ASSOCIATED WITH YOUR VISIT TODAY. IT IS NORMAL NOT TO HAVE MOST OF THESE SYMPTOMS.

CONSTITUTIONAL [ ] Fatigue [ ]Weight Loss [ ]Weight Gain [ ]Other___________

EYES [ ]Glasses/Contacts [ ]Other___________

HEAD/NECK [ ]Sinus Congestion [ ]Dentures [ ]Decreased Hearing [ ]Other___________

BREAST [ ]Lumps [ ]Tenderness [ ]Nipple Discharge [ ]Other___________

CARDIOVASCULAR [ ]Chest Pain [ ]Irregular Heart Beat [ ]Fainting [ ]Other___________

RESPIRATORY [ ]Shortness of Breath [ ]Wheezing [ ]Cough [ ]Other___________

GASTROINTESTINAL [ ]Nausea [ ]Vomiting [ ]Diarrhea [ ]Constipation [ ]Blood in Stools [ ]Other___________

GENITOURINARY [ ]Urgency [ ]Frequency [ ] Dysuria [ ]Incontinence [ ]Decreased Libido [ ]Other___________

SKIN [ ]Rash [ ]Changes in Moles [ ]Changes in Lesions [ ]Other___________

NEUROLOGICAL [ ]Muscular Weakness [ ]Incoordination [ ]Tingling/Numbness [ ]Other___________

MUSCULOSKELETAL [ ]Joint Pain [ ]Muscle Pain Other_____________

ENDOCRINE [ ]Frequent Urination [ ]Constant Drinking [ ]Cold Intolerance [ ]Heat Intolerance [ ]Other___________

PSYCHIATRIC [ ]Anxiety [ ]Depression [ ]Difficult Sleeping [ ]Other___________

HEME-LYMPH [ ]Easy Bleeding [ ]Easy Bruising [ ]Lymph Node Pain

ALLERGIC-IMMUNE [ ]Sinus Symptoms [ ]Frequent Illness [ ]Other___________

MENSTRUAL HISTORY

Menses began ______y/o Cycle Interval ______days Duration _____ days [ ] light [ ] medium [ ] heavy

Last period ___________

Birth Control Method_________________ [ ] Home Pregnancy Test [ ] Positive [ ] Negative

[ ] Peri-menopause [ ] Menopause Age began__________

____

Reason for visit ____DATE___________

Last Annual exam: Date_______________

Last Colonoscopy: Date_______________ Result_____________________________________

Last Diabetes Screen: Date____________ Result_____________________________________

Last Cholesterol Screen: Date__________ Result_____________________________________

Last Mammogram: Date______________ Result_____________________________________

Last Osteoporosis Screen: Date_________ Result_____________________________________

Last Pap Screen: Date________________ Result_____________________________________

Last Thyroid Screen: Date_____________ Result_____________________________________

PAST GYNECOLOGICAL HISTORY

[ ]Birth control [ ]Ectopic Pregnancy [ ]No Periods Type_________ [ ]Endometriosis [ ]Abnormal Bleeding

[ ]Cervical Dysplasia [ ]Fibroids [ ]Painful Periods [ ]Fluid in fallopian tubes [ ]Herpes [ ]Pelvic Pain

[ ]Vaginal Dysplasia [ ]Infertility [ ]Pelvic Infection [ ]Vulvar Dysplasia [ ]Menopause [ ]Pelvic Mass

Other____________________ [ ]Pelvic Prolapse

PAST MEDICAL HISTORY

[ ]Abnormal Mammogram [ ]Elevated Prolactin [ ]Anemia [ ]Breast Cyst [ ]Hyperthyroid [ ]Blood Transfusion in past

[ ]Fibrocystic Breast Disease [ ]Hypothyroid [ ]Coagulation Disorder [ ]Breast Discharge [ ]Metabolic Syndrome

[ ]Varicose Veins [ ]Breast Mass [ ]Obesity [ ]Blood clot in leg/lung

[ ]Breast Pain [ ]Polycystic Ovarian Syndrome [ ]Von Willebrand's Disease [ ]Cancer Type_____________

[ ]Lupus [ ]Chronic Back Pain [ ]High Blood Pressure [ ]Anal Fissures [ ]Fibromyalgia

[ ]High Cholesterol [ ]Constipation [ ]Osteopenia [ ]Heart Palpitations [ ]Reflux Disease/Heartburn [ ]Osteoporosis

[ ]Mitral Valve Prolapse [ ]Hemorrhoids [ ]Headaches/Migraines [ ]Diabetes Type___________ [ ]Irritable Bowel Syndrome

[ ]Seizure Disorder [ ]Seasonal Allergies [ ]Interstitial Cystitis [ ]Alcohol/Drug Abuse [ ]Asthma [ ]Bladder urgency

[ ]Anxiety Disorder [ ]COPD/Obstructive Bronchitis [ ]Protein/Blood in Urine [ ]Bipolar Disorder [ ]Chronic Sinusitis

[ ]Kidney/Bladder Infections [ ]Depression [ ]Incontinence/Loss of urine

[ ]Other__________________ _________________________ [ ]Kidney Stones

PAST GYNECOLOGICAL SURGERY

[ ]Cesarean Section Number____________ Reason_____________________________

[ ]Ectopic Pregnancy Side_______________ Treatment___________________________

[ ]Hysteroscopy Date______________ Diagnosis___________________________

[ ]Hysterectomy Date______________ Diagnosis/Type_______________________

[ ]Ovaries Removed Reason_____________________________

[ ] [ ]Laparoscopy Date______________ Diagnosis___________________________

[ ]Prolapse/Incontinence Date______________ Type_______________________________

[ ]Sterilization Date______________ Type_______________________________

PAST SURGERIES

[ ]Hand Surgery [ ]Chest Surgery [ ]Abdominal Surgery [ ]Hemorrhoid Surgery [ ]Thyroid Removed

[ ]Ankle Surgery [ ]Hernia Repair [ ]TMJ Surgery [ ]Appendix [ ]Knee Surgery [ ]Tonsils/Adenoids

[ ]Bariatric - LapBand [ ]Lasik [ ]Hip Replacement [ ]Bariatric – Roux-en-Y [ ]Spine Surgery [ ]Knee Replacement

[ ]Bronchoscopy [ ]Neck Surgery [ ]Other__________________ [ ]Cataract Surgery

[ ]Plastic Surgery __________________ [ ]Gall Bladder Removed [ ]Shoulder Surgery [ ]Colonoscopy [ ]Sinus Surgery

[ ]Brain Surgery [ ]Skin Biopsy [ ]Bladder Scope [ ]Skin Tag Removal [ ]Foot Surgery [ ]Spleen Removed

MEDICATIONS

TYPE DOSE DATE STARTED

____

____

____

ALLERGIES ____

FAMILY HISTORY

[ ]Breast Cancer___________ [ ]Heart Disease___________ [ ]Sickle Cell Disease/Trait [ ]Colon Cancer____________

[ ]Thyroid Disease__________ [ ]Lupus [ ]Kidney Cancer___________ [ ]Hypo [ ]Hyper [ ]Blood Clots/Coagulation

[ ]Ovarian Cancer__________ [ ]Osteoporosis [ ]Von Willebrand's Disease [ ]Prostate Cancer__________

[ ]Problems w. Anesthesia []Other___________________

[ ]Uterine Cancer__________

OFFICE FINANCIAL POLICY

Thank you for choosing Seasons Midwifery & Birth Center for your health needs. Our goal is to provide and maintain a good provider-client relationship. Letting you know in advance about our office policies allows for a good flow of communication and enables us to achieve our goal.

Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

Insurance Plans

- It is your responsibility to keep Seasons Midwifery & Birth Center up to date with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment for the visit.
- We must emphasize that, as your medical provider, our relationship is with you, not your insurance company. As a courtesy, we file your medical claim to your insurance at no charge.
- According to your insurance plan, you are responsible for any and all copayments, deductibles, and co-insurances. We do ask that you pay all co-pays, deductibles, and non-covered charges the day of your service.
- SMBC calls and verifies benefits for procedures and birth services. However, it is still the client's responsibility to know their benefits and we encourage you to contact your insurance as well.
- SMBC will keep a confidential credit/debit card on file with us. This information is stored in a secure system that complies with Payment Card Industry Data Security Standard. You will have the option to have balances automatically run (for your convenience) or be contacted by the Billing Department prior to running your card for unpaid balances.
- Please always feel free to contact our Billing Department with any concerns, questions, or information regarding your account.

Self-Pay

If you do not have insurance, self-pay patients will be expected to pay at the time of service. Procedures and birth services will be discussed with the patient for payment prior to the procedure being performed.

SIMPLE SOLUTIONS

I, _________________________________ authorize The Women's Health Group, P.C./Seasons Midwifery & Birth Center to charge my credit card for payments due including my co-pays, co-insurance, deductible, non-covered charges and charges billed but not paid by my insurance company within 60 days. I understand the process is:

- SMBC will bill my insurance and wait for insurance to pay

- SMBC will then send me 2 statements over a 60 day period (I have the option to pay however I want – check, credit card, etc.)

- If no payment is received in 60 days, SMBC will attempt to contact me to arrange for payment.

- If we receive no response after mailed statements, phone calls, and/or emails, the "Patient Responsibility Amount" shown on my Explanation of Benefits (EOB), will be transferred to my credit card as listed below.

Options:

☐ Process my credit card automatically.

☐ I prefer a courtesy call (phone) ____________ or (email) ___________________ to alert me to the processing date of the credit card.

I understand that The Women's Health Group, P.C./Seasons Midwifery & Birth Center will submit my claims to the insurance company as a courtesy, but timely payment to my account is my responsibility.

I assign my insurance benefits to The Women's Health Group, P.C./Seasons Midwifery & Birth Center. I authorize The Women's Health Group, P.C./Seasons Midwifery & Birth Center to maintain my credit card information on file for SIMPLE SOLUTIONS purposes only

____ ______________

Cardholder signature Date

This form will be renewed annually and upon expiration of credit card

Patient
Name____Phone:__________________

Cardholder Name (Please Print)

____

Cardholder Address (Please Print)

____

City, State, Zip (Please Print)

____

Circle one: Visa MasterCard Discover HSA (Health Savings Account)

Credit Card Number____________________________Exp:_____Security Code______

Of fice use only:
Account Number______________Date Entered_________________Approved_____Declined_____Initials_________

OFFICE POLICIES

After-Hour Emergencies

If you should experience a life-threatening emergency, please call 911 or go to the closest emergency room.

If you have other after-hours emergencies, you may contact the midwife on-call by calling our main number. This service is for emergency or potential emergency care only. Please call during regular business hours for non-urgent questions or concerns.

Late Appointment Arrival

We ask that all patients arrive at the designated time. If you do arrive late for your appointment, we may need to see other clients before we can see you. In addition, if you are more than 15 minutes late, you may be asked to reschedule.

Cancellations and No-Shows

As a courtesy to other clients, we request that you notify SMBC as soon as possible if you need to change your appointment. This allows us to offer that appointment time to another client. We understand that sometimes unforeseen circumstances may arise on the day of your appointment. But we ask you give notice as soon as possible (24 hours if possible) if you will not be able to make your appointment. If you have missed your appointments 3 times and have not cancelled or rescheduled, you may be dismissed from our practice.

Seasons Midwifery & Birth Center strives to offer you the very best care; therefore, we have implemented these policies to continue providing premium care to all of our clients.

I have read and understand the Financial/Office Policies:

____ ________________________

Patient/Responsibility Party Signature Date

____ ____________________

Print Patient Name Date of Birth

PRIVACY NOTICE ACKNOWLEDGEMENT

I received a copy of Seasons Midwifery & Birth Center's Notice of Privacy Practices.

____

Printed Name

____ __________________________

Patient Signature Date

**A copy of the Privacy Practices can be found on our website on the Forms page. Signing this acknowledgement confirms you are aware of our Privacy Policy. If you would like a paper copy of our policy, please ask the receptionist.

APPOINTMENT CHECKLIST

Forms (filledoutcompletely)

Insurance card

PhotoI.D.(Driver’slicenseorotherstateissuedidentificationcard)

Co-payment (cash,check,creditcard)

Simple Solutionspaperwork

****

QUESTIONS I WANT TO REMEMBER TO ASK THE MIDWIFE:

___

___

___

___

___

PATIENT HIPAA QUESTIONNAIRE AND ACKNOWLEDGEMENT

I have received a copy of Seasons Midwifery & Birth Center Notice of Privacy Practices.

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

Name:____ Phone:____________________

Name:____ Phone:____________________

II. Please list the family members or significant others, if any whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name: ____Phone:____________________

Name: ____Phone: ____________________

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

____

IV. Please print the telephone number where you want to receive calls about your appointments, lab results, or other health care information if other than your home phone number:

Phone ____

* I am fully aware that a cell phone is not a secure and private line.

* I am fully aware my health information can be transmitted by facsimile (fax), mail, email, or the internet.

V. Can confidential messages (i.e., appointment reminders) be left on your home answering machine or voicemail? YES NO

PATIENT NAME ____

PATIENT SIGNATURE ____

DATE ____