Initial Paperwork & Consents

Please turn these forms in to the front desk by the end of your first visit. Some of these should be reviewed with the midwife or nurse during your appointment. Please don't sign anything you don't understand or don't agree with. We will be happy to review all items with you in person. Inside you will find:

- Birth Center & Pregnancy Care Agreement – this consent form is all about what to expect from community based pregnancy care and birth.
- Insurance Questionnaire – this form is for our billing office. It will help us streamline insurance billing for your care. If you are self-pay you do not need this form. Be sure to include any active insurance policies you have.
- HIPAA Questionnaire – this gives us permission to contact you or anyone of your choosing about your care.
- Client Rights – your rights as a client here
- Lab Tests in Pregnancy – These are the routine tests that you can expect during your pregnancy.
- Genetic Screening – this is information about optional testing you can have in pregnancy.
- Cystic Fibrosis – a recommended screening to see if you are a genetic carrier of this disease.
- PDR Consent form & Worksheet– birth centers collect anonymous data about pregnancy and birth to help with research, and keep this kind of care safe and available to families who choose it.
- Media Release – this gives us permission to celebrate with you after the birth of your baby, in a more public way.

*****Please let us know if you would like to keep copies of any forms you sign. They contain helpful information that you may want to review at a later time.***

Birth Center & Pregnancy Care Agreement

Our center is designed to support normal family centered care during the childbearing year. Like all community birth options, it may meet the needs of some, but not all families seeking this type of care. We believe strongly in true informed consent! Therefore we ask you to read, and note that you understand the type of care you are asking to receive in our facility.

- The care offered at Seasons is provided by Certified Nurse Midwives, Registered Nurses and Medical Assistants all practicing in accord with the expertise of their own discipline. We do have physicians on staff that can participate in your care should the need arise. As the physicians do not participate in birth center birth, they will not be a normal part of your routine care, nor will they be present at your birth. You will receive your prenatal, birth and postpartum care from Certified Nurse Midwives, Nurses, MA's, students and other trusted members of our staff.
- Your safety, comfort and satisfaction are our primary concern. As such we have all necessary equipment, medication and other medical supplies needed for normal childbearing in the community setting. You must understand that WE ARE NOT A HOSPITAL. We do NOT have an operating room or intensive care unit. We do not have surgeons in the facility nor do we have an anesthesiologist available. These services are available at our local hospital. Although community birth is a thriving, safe and normal option for low risk families, there are some professional organizations that oppose this type of care. They feel that there are certain inherent risks to any birth happening outside of a hospital.
- In case of emergency you will be transferred to a nearby hospital. A member of our clinical team will accompany to the hospital, where your care *may* be continued by members of our practice if available and appropriate.
- All hospital expenses or those incurred by the care of an unaffiliated provider at any time will by your responsibility.
- Seasons will be happy to provide well care for your newborn up to the first two weeks of life. At that time their care will be taken over by the pediatric care provider of your choice. We will guide you how to make these arrangements during your pregnancy.

- The best care for you and your family happens when we all engage in open and honest dialogue. If at any time you have questions or concerns in regards to your care we ask you to talk with us. We have a grievance policy in place if you feel that we did not adequately address your concerns.
- Acceptance to our practice can only occur after a review of your health history, physical examination and review of lab testing has occurred. Only families who remain low risk throughout their pregnancy will be admitted to the birth center in labor.

Your signature on this form acknowledges your understanding of the above statements and that all of your questions have been answered to your satisfaction.

Printed Name:___________________________________ Date of Birth ________

Signature: ______________________________________ Date _______________

Partner Signature ____

Insurance Questionnaire

Name: ____________________________Date of Birth:_____________________

Due Date__________Is there a different name on your insurance card? YES   NO

If yes, please write it here and explain ___________________________________

Insurance: Aetna   Humana   Cigna   Anthem Blue Cross/Blue Shield   UMR

United Healthcare   Golden Rule   Tricare   CHP+   Medicaid   Kaiser

Other: _______________________ Effective Dates ________________________

Who is the primary insured person? Self

Spouse _________________ Parent __________________ Other______________

Primary's Date of Birth _____________________ SSN______________________

Primary's Place of Employment ____

Address of Employment ____

Phone number of Employer ____

Secondary Insurance?   Yes   NO

____

ASSIGNMENT OF BENEFITS AND AGREEMTN 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: ___________________

HIPAA Questionnaire and Acknowledgement

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

1. Please list the family members or other persons, if any, whom we may inform about your general health, including treatment & payment.

   Name ____________________________ Phone ______________________

   Name ____________________________ Phone ______________________
2. Please list the family members or partners if any whom we may inform about your medical condition ONLY IN AN EMERGENCY

   Name ____________________________ Phone ______________________

   Name ____________________________ Phone ______________________
3. Please print the address of where you would like any billing statements or other correspondence from our office to be sent if other than your home.

   ____

4. 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/cell number ____
   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 fax, mail, email or the internet.

5. Can confidential messages be left on your voicemail? YES NO

Printed Name ____

Signature ____ Date______________

Client Rights

All clients of Seasons Midwifery & Birth Center have the right to:

- Receive services without regard to age, race, color sexual or gender orientation, religion, marital status or national origin.
- Be treated with consideration, respect and dignity including privacy in treatment.
- Be informed of the provisions for off-hour emergency coverage.
- Receive an itemized copy of their account statement upon request
- Obtain from their health care providers complete and current information concerning diagnosis, treatment and prognosis in terms that can be reasonably understood so that clients may participate in the management of their care.
- Receive from their providers, information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved and alternatives for care or treatment if any.
- Determine for themselves, without pressure from their providers, whether they will accept the risks inherent in the proposed therapy of screening procedure or refuse the drug or procedure and to be informed of the medical consequences of their actions.
- The right to discontinue care at any time, including request of transfer of care to the closest medical facility.
- Refuse to participate in student education programs or research projects.
- Voice grievances and recommend changes in policies and services to the birth center's staff without fear of reprisal.
- File written complaints with the Director of Midwifery, Administrative Director or ownership around any aspect of their care.
- Be accompanied during their labor and birth process by anyone they choose.
- Privacy and confidentiality of all information and records pertaining to their treatment of care.

I have read and understand my rights as a client of Seasons Midwifery & Birth Center.

Printed Name Signature Date

Lab Tests in Pregnancy

We believe pregnancy is a state of health and that an important part of preventative care involves performing lab testing. The listed tests will be ordered as part of healthy pregnancy monitoring and as required by our state regulations. Please read over this form and ask the midwife any questions you have about these tests. Please note, any labs that have already been performed with another provider will not be repeated IF we are able to obtain copies in a timely manner.

- Complete blood count
- Blood type
- Rh and antibody screen (also on cord blood if indicated)
- Rubella status
- Hepatitis B and C
- Syphilis
- HIV
- Chlamydia
- Gonorrhea
- Urine Culture
- Gestational Diabetes Screening
- Group Beta Strep
- Colorado State Metabolic Screening Test (for newborns)

Some Clients may need additional testing. Some, but not all of these tests may include

- Thyroid tests
- Early Diabetes Screening
- Pap smear if needed
- Other STI testing

Optional tests include

- Toxoplasmosis Screening
- Cystic Fibrosis Screening (separate consent form)
- Genetic Testing

The above listed tests are for health screening purposes. If there is a clinical indication for additional testing, a staff member will discuss it with you at that time.

I have read and understand the above information and have had my questions answered.

____

Printed name Signature Date

Genetic Screening

There are several options available in pregnancy in regards to genetic screening tests. Some methods require a simple blood test, while others are more invasive and associated with some risk. Genetic testing cannot detect the majority of birth defects that could affect a fetus and no test can guarantee a perfect baby.

The following is a brief summary of that testing is available along with some of the advantages and disadvantages. These tests are all considered optional.

1st Trimester (11-14 weeks) – Currently the standard of prenatal care is to offer second trimester testing. Until recently no testing was available to detect chromosomal abnormalities like Down syndrome in the first trimester that was not invasive. Currently there are three options.

- First Trimester Screen – Genetic Screen with Pre-Eclampsia risk assessment: This is a non-invasive blood test will use 4 biochemical markers in concert with two ultrasound measurements (nuchal translucency measurement and nasal bone presence) to screen. It is a 95% - 96% sensitive test with a false positive rate of 2% (this implies that we pick up 95% of these chromosomal abnormalities while only 2% of normal fetuses will screen positive). We will also be able to provide a risk assessment for developing pre-eclampsia with the biochemical markers as well as a uterine blood flow measurement.
- NIPD – Noninvasive Prenatal Testing – The Informed Pregnancy Screen is a noninvasive blood test that is available for people with increased risk indicators for fetal chromosome variations at 10 weeks of pregnancy and beyond. This test detects an increased amount of chromosomal material that is circulating in maternal blood. Examples of increased risk factors where we would be likely to offer this test include one or more of the following; age 35 or over, positive serum screening test, fetal ultrasound abnormality or family history of chromosomal abnormalities.
- Chorionic Villus Sampling (CVS) – this is an invasive test requiring sampling of placental tissue from within the uterus. Generally this is reserved for clients at high risk for chromosomal abnormalities or with an abnormal First Trimester Screen. Risks associated with the procedure include the possibility of miscarriage and rarely, limb defects. Clients who desire this form of testing are referred to a specialist trained in the technique.

2nd Trimester - The following tests are routinely offered in the second trimester

- Quad Screen – this is a non-invasive blood test offered between 16 and 20 weeks which screens for Down syndrome, Neural tube defects and trisomy 18. The test will detect approximately 80% of babies with Down syndrome and 80%-90% of babies with neural tube defects. The detection rate is lower than the First Trimester Screen.

- Amniocentesis – this is an invasive test that involves placing a needle in the uterus and withdrawing amniotic fluid for analysis. The procedure is routinely offered to people over 35 who are at an increased risk for genetic abnormalities such as Down syndrome. It is also offered when someone has an abnormal genetic screening test or abnormal ultrasound. The advantage of this test is that is gives definitive information regarding genetic abnormalities with a detection rate of nearly 100%. The risk associated with this procedure is the possibility of miscarriage which occurs in approximately 1/250 procedures.
- Ultrasound – This is a noninvasive test routinely performed at 20 weeks which allows visualization of the baby. Ultrasound can detect many fetal abnormalities including those associated with Down syndrome and neural tube defects. However, the detection rate is still approximately 80% when used in combination with the Quad Screen.

With so many insurance companies and differing coverage policies, ***it is impossible for us to determine what coverage you may have for any of these tests***. If you are interested in obtaining genetic screening, review your options with the midwife and she will complete the information below. After your consultation, we suggest you visit the website for the lab **Counsyl.com** and input your insurance information to get an estimate on your possible out-of-pocket costs, or call them at **(888) COUNSYL**. We strongly recommend contacting your insurance company for more information about coverage and benefits, as these tests can have high out of pocket costs.

Diagnosis Codes (ICD-10) - circle all that apply

Z34.90 Supervision of normal pregnancy O09.519 Advanced maternal age 1st pregnancy

O09.529 Advanced maternal age subsequent pregnancy O09.299 History of fetal abnormality

Z84.89 Family history of genetic disorder
Other:____

Procedure codes (CPT)

*MFS-T1 With preeclampsia risk – 84163, 84704, 82105, 86336, 83520

*Preeclampsia risk only- 84163, 82105, 83520 *AFP – 82105

*Quad screen- 82105, 84704, 82677, 86336 *Prelude screen - 81420

*Cystic Fibrosis- 81220

Cystic Fibrosis Carrier Screening

What is Cystic Fibrosis?

Cystic Fibrosis (CF) is a common genetic condition characterized by the production of abnormally thick, sticky mucus, particularly in the lungs and digestive system.

It is recommended that those who are pregnant or considering becoming pregnant have a Cystic Fibrosis carrier screen. Cystic Fibrosis is the most common deadly inherited condition among many ethnicities. You only need to be tested once in your life for this. Please let us know if you have been tested during a prior pregnancy or at another time.

Choose one of the following

_______ I have already had testing and do not need further screening

_______ I have been informed about CF testing and I choose to DECLINE genetic testing at this time.

_______ I desire to have genetic testing to see if I am a genetic carrier of CF

Printed name Signature Date

AABC Perinatal Data Registry™

(Originally known as the AABC Uniform Data Set)

Information & Consent Form

1. Title of Data Collection Form: ***American Association of Birth Centers' Perinatal Data Registry™***
2. Administrator: Kate Bauer, MBA and Susan Stapleton, DNP, CNM
3. Purpose: The purpose of this data set is to:
   a. Help improve and maintain quality of care of childbearing families;
   b. Provide for ongoing and systematic collection of data on normal birth; and
   c. Facilitate research on maternity care practices that support optimal birth.
4. Procedures: Participation in this data collection involves allowing information from your medical record regarding your pregnancy to be entered into a secure online data registry. The care that you receive during your pregnancy, labor, birth and postpartum, and the care that your newborn receives, will not be altered in any way as a result of your participation in this data registry. Your health record from your pregnancy may also be reviewed by one of the project administrators during a site visit to the practice in which you are receiving maternity care in order to confirm that the data entered in the data registry is accurate.
5. Risks: The risks involved with participation in this project are no more than one would experience in regular daily activities.
6. Benefits: Potential benefits of participation in this project include the satisfaction of knowing that you have helped to support the development of midwives, birth centers and the midwifery model of care, thus contributing to making this model of maternity care more widely available to families.
7. Data Collection & Storage: All information about you and your pregnancy will be kept confidential and secure, and only the people working with the project will see your data. No one except your care provider will be able to connect the data collected with you specifically. As required by the federal Privacy Rule (HIPAA), no identifying information will be seen by those conducting the project except your date of birth and your 5-digit zip code. Your data will be kept on file, and may be used later by other researchers who are studying specific parts of birth center or midwifery care. Your information will be completely de-identified prior to being used by any researcher, and all information, including your date of birth and zip code, will be removed.
8. Contact Information: For related problems or questions regarding your rights, or other questions about the data registry, you may contact the American Association of Birth Centers at 866-54-BIRTH or (215) 234-8068.
9. Consent Statement: I have read or had read to me the proceeding information describing the project. All of my questions have been answered to my satisfaction. I am 18 years of age or older, or am considered an "emancipated minor" because I am pregnant. I freely consent to participate, and also give permission for data about my newborn to be used. I understand that I am free to withdraw from the project at any time without penalty. I understand that my care during pregnancy will not be affected in any way by whether or not I participate in this project. I have received a copy of this consent form.

Signature of Client ______________________________ Date ____________

Signature of Provider ______________________________ Date ____________

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Media Release

Sometimes our families like to share birth announcements, pictures stories and videos with us, either in our office or in social media. We DO NOT take pictures or videos of clients without your express consent or at your request. This form gives us permission to share items that you share with us, like hanging up your birth announcement in our waiting room. You can decline sharing or revoke your permission at any time.

This form releases Seasons Midwifery & Birth Center and it's representatives, employees, managers, members, officers, subsidiaries, subcontractors, owners and directors from all claims and demands arising out of or in connections with any use of said "materials" including and without limitation all claims for invasion of privacy, infringement of my right or publicity, defamation and any other personal and/or property rights.

Choose one of the following and sign the bottom of the form:

______ I grant Seasons Midwifery & Birth Center permission to post my photo, story, video or other item to their website, social media accounts, online learning materials or slideshows. Seasons will not use my name or my child's name without my permission. I understand that no sums whatsoever will be due to me as a result of the use and/or exploitation of the materials or any rights therein.

______ I decline the release to use any items, and ***I will not share*** any birth announcements, photos or other materials with Seasons.

Printed name Signature Date