



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

In order to be sure all information is current and eliminate some of your waiting time, we are enclosing your yearly 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 at 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

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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
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_____	_____	_____
_____	_____	_____
_____	_____	_____

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 (filled out completely)

Insurance card

Photo I.D. (Driver's license or other state issued identification card)

Co-payment (cash, check, credit card)

Simple Solutions paperwork

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 _____
